

Neurological Rehabilitation Center LLC

Patient: Black ink,
Doctor: Red ink

Thank you for carefully
answering each question!

Patient Name: _____ Date: _____

Motor Vehicle Accident Health History Form (Page 1):

Date of the accident: _____ Approximate time of the accident: _____

Your Vehicle

What is the make & model of your car/truck? _____ What is the year? _____

Were you the: Driver Front right passenger Front middle passenger Rear passenger, driver's side
Rear passenger, right side Rear middle passenger Other: _____

At the time of the accident what kind of surface were you driving on? Dry pavement. Wet pavement. Gravel. Dirt. Other: _____

Were you restrained by a seatbelt? No. Yes. If yes, what kind? Shoulder and lap belts Shoulder only Lap only

Did your seat have a headrest? No. Yes. Where was the top of the headrest positioned in relation to the top of your head?
above my head below my head level with my head

Do you recall how far your headrest was from the back of your head? No. 0-1 inches. 1-3 inches. 3 or more inches.

The Other Vehicle(s)

How many vehicles struck your car/truck? _____ If more than 1 please ask for another sheet of paper and answer the
questions in this table for each vehicle.

What is the make & model of their car/truck? _____ What is the year? _____

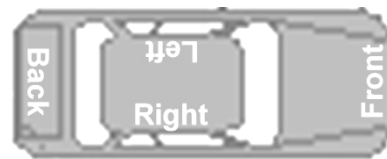
The Accident

Approximately how fast were you going at the time of impact? _____ mph. Approximately how fast was the other car going at the time of impact? _____ mph. About how far did your car move after being struck? _____ feet.

If you were car was standing still at the point of impact, where was your foot or feet? Pressed on the brake. Resting on the break. off the break.

Where was your head facing when the collision occurred? Looking right at rearview mirror. Looking right through a window. Looking left through a window. Looking right through back window. Looking up. Looking down.

On the diagram to the right, please mark the point(s) of impact on to your vehicle.



Which direction did the striking vehicle come from? Head on (from front). From behind. From right. From left.
Diagonal or obliquely from: _____

After the accident did you strike anything else? No. Yes. If yes, describe: _____

Was there any damage done to your vehicle? No. Yes. If yes, how extensive: _____

Was there any damage done to the other vehicle? No. Yes. If yes, how extensive: _____

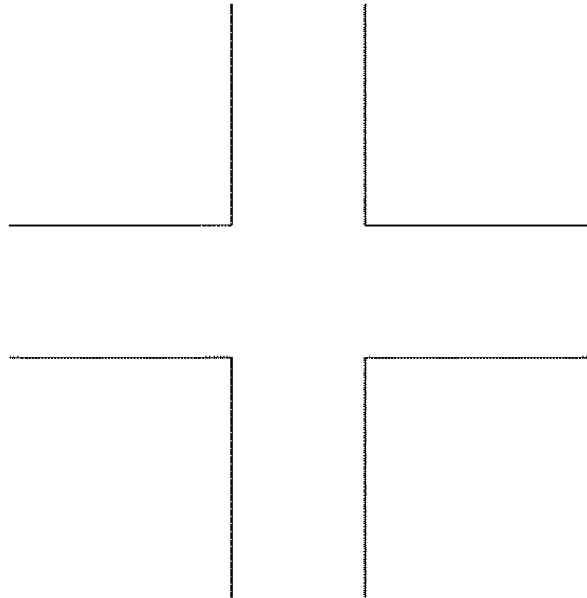
Did your airbags deploy? No. Yes. If yes, which airbags: _____

Did the police arrive? No. Yes. If yes, was a report made? _____

Motor Vehicle Accident Health History Form (Page 2):

The Accident, in your words:

Below please describe in your words how the accident occurred, use the diagram of an intersection if helpful:



Injuries:

Were you aware of the collision as it occurred? No. Yes. If yes, then did you brace your arms and legs? No. Yes. Did you lose consciousness at any point during or after the collision? No. Yes.

Were you ejected from the vehicle? No. Yes. If yes, describe:

Did any part of your body strike the interior of your vehicle? No. Yes. If yes explain: _____

Did you sustain any injuries occur outside of your vehicle? No. Yes. If yes explain: _____

Did you have any pain as a result of the collision? No. Yes. If yes explain: _____

Did you suffer any bruises, cuts, or broken bones from the collision? No. Yes. If yes explain: _____

Did you suffer any of the following symptoms (mark all that apply)? Dizziness. Light headedness. Severe headache. Vertigo. Blurry vision. Confusion. Memory loss. Extreme drowsiness. Difficulty with focus or concentration. Sensitivity to light. Visual disturbances. Nausea. Vomiting. Muscle weakness. Numbness or tingling. Ringing in ears. Difficulty sleeping. Difficulty with speech. Feelings of depression or sadness. Feelings of nervousness or anxiety. Crying for no reason. Other: _____

Motor Vehicle Accident Health History Form (Page 3):

Medical History

Did you go to the hospital after the accident? No. Yes. If yes, please answer the five questions below:

1. Did you travel by: Ambulance? Your car? Another car?
2. How long after the accident did you arrive at the hospital? _____.
3. How did you leave the hospital? Someone drove me. I drove myself.
4. Were x-rays or other imaging procedures performed? No. Yes. If yes, explain: _____
5. Did you receive treatment or any prescription/medications at the hospital? No. Yes. If yes, explain: _____

Other than the hospital, have you visited any other health care providers since the accident? No. Yes. If yes, explain (include names and phone numbers): _____

Have you ever been involved in a motor vehicle accident before? No. Yes. . If yes, please answer the five questions below:

1. When and where did the accident(s) occur? a. _____
If more than 3, please ask for another sheet of paper b. _____
c. _____
2. Who did you see for care? a. _____
If more than 3, please ask for another sheet of paper b. _____
c. _____
3. What type of care did you receive? a. _____
If more than 3, please ask for another sheet of paper b. _____
c. _____
4. Did all of your symptoms resolve from the above mentioned accidents? No. Yes. If not, what symptoms persisted? _____

Did any remaining symptoms affect your daily activities in any way? No. Yes. If yes, explain: _____

Impact on Your Life:

Please mark the activities below that have been adversely affected, or are difficult to perform, since your motor vehicle accident.

Domestic Activities:

- | | | | |
|-----------------------------------|--|--|------------------------------------|
| <input type="checkbox"/> Cleaning | <input type="checkbox"/> Folding laundry | <input type="checkbox"/> Moving items | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Getting into/out of bed | <input type="checkbox"/> Lifting objects | <input type="checkbox"/> Vacuuming |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Holding bowls or cups | <input type="checkbox"/> Sitting down | <input type="checkbox"/> Other: |

Personal Care Activities:

- | | | | |
|--|--|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Combing hair | <input type="checkbox"/> Nail care | <input type="checkbox"/> Toilet care | <input type="checkbox"/> Shaving |
| <input type="checkbox"/> Brushing teeth | <input type="checkbox"/> Showering | <input type="checkbox"/> Bathing | <input type="checkbox"/> Gargling |
| <input type="checkbox"/> Applying makeup | <input type="checkbox"/> Shampooing hair | <input type="checkbox"/> Dressing | <input type="checkbox"/> Other: |

Relationship Activities:

- | | | | |
|----------------------------------|--|---|---------------------------------|
| <input type="checkbox"/> Hugging | <input type="checkbox"/> Laughing | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Kissing | <input type="checkbox"/> Holding hands | <input type="checkbox"/> Personal relationships | |

Motor Vehicle Accident Health History Form (Page 4):

Child Care Activities:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Carrying your child | <input type="checkbox"/> Bathing your child | <input type="checkbox"/> Packing lunch | <input type="checkbox"/> Pushing a stroller |
| <input type="checkbox"/> Changing diapers | <input type="checkbox"/> Breast feeding | <input type="checkbox"/> Picking up your child | <input type="checkbox"/> Toweling after bath |
| <input type="checkbox"/> Washing/shampooing | <input type="checkbox"/> Bottle feeding | <input type="checkbox"/> Playing with your child | <input type="checkbox"/> Other |
| <input type="checkbox"/> Entertaining your child | <input type="checkbox"/> Rocking your child | <input type="checkbox"/> Hugging your child | |

Sports & Athletic Activities:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Football | <input type="checkbox"/> Racquet sports | <input type="checkbox"/> Table tennis |
| <input type="checkbox"/> Archery | <input type="checkbox"/> Golf | <input type="checkbox"/> Rafting | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Rollerblading | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Badminton | <input type="checkbox"/> Handball | <input type="checkbox"/> Rock climbing | <input type="checkbox"/> Waterskiing |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Horseback riding | <input type="checkbox"/> Roller skating | <input type="checkbox"/> Weight training |
| <input type="checkbox"/> Biking | <input type="checkbox"/> Hunting | <input type="checkbox"/> Rugby | <input type="checkbox"/> Wind surfing |
| <input type="checkbox"/> Boogie boarding | <input type="checkbox"/> Ice skating | <input type="checkbox"/> Soccer | <input type="checkbox"/> Working out |
| <input type="checkbox"/> Bowling | <input type="checkbox"/> Jet skiing | <input type="checkbox"/> Softball | <input type="checkbox"/> Wrestling |
| <input type="checkbox"/> Camping | <input type="checkbox"/> Jogging | <input type="checkbox"/> Snowmobiling | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Canoeing | <input type="checkbox"/> Martial arts | <input type="checkbox"/> Snowboarding | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Cross country skiing | <input type="checkbox"/> Mountain biking | <input type="checkbox"/> Surfing | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Down hill skiing | <input type="checkbox"/> Pilates | <input type="checkbox"/> Swimming | |

Social Activities:

- | | | | |
|---|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Religious practices | <input type="checkbox"/> Movies | <input type="checkbox"/> Shopping | <input type="checkbox"/> Going out |
| <input type="checkbox"/> Picnics | <input type="checkbox"/> Eating out | <input type="checkbox"/> Music events / concerts | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Sightseeing | <input type="checkbox"/> Entertaining | <input type="checkbox"/> Dancing | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Visiting friends/relatives | <input type="checkbox"/> Vacationing | <input type="checkbox"/> Walking | |

General Household Activities:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Mowing the lawn | <input type="checkbox"/> Yard work | <input type="checkbox"/> Car maintenance | <input type="checkbox"/> Shoveling snow |
| <input type="checkbox"/> Fertilizing | <input type="checkbox"/> Clearing brush | <input type="checkbox"/> Washing car | <input type="checkbox"/> Taking out the trash |
| <input type="checkbox"/> Tree trimming | <input type="checkbox"/> Raking | <input type="checkbox"/> Using tools | <input type="checkbox"/> Walking the dog |
| <input type="checkbox"/> Watering the lawn | <input type="checkbox"/> Cleaning the gutters | <input type="checkbox"/> Painting | <input type="checkbox"/> Caring for pets |
| <input type="checkbox"/> Weeding | <input type="checkbox"/> Spraying | <input type="checkbox"/> Hammering | <input type="checkbox"/> Other |

Activities that Impact your Career:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Attendance at work | <input type="checkbox"/> Grasping actions | <input type="checkbox"/> Prolonged walking | <input type="checkbox"/> Stairs |
| <input type="checkbox"/> Performance at work | <input type="checkbox"/> Group tasks | <input type="checkbox"/> Perform required tasks | <input type="checkbox"/> Telephone operation |
| <input type="checkbox"/> Bending activities | <input type="checkbox"/> Heavy work | <input type="checkbox"/> Pushing actions | <input type="checkbox"/> Tool operation |
| <input type="checkbox"/> Bookkeeping | <input type="checkbox"/> Keyboarding | <input type="checkbox"/> Pulling actions | <input type="checkbox"/> Transportation to work |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Lifting objects | <input type="checkbox"/> Reaching actions | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Machine operation | <input type="checkbox"/> Reading | <input type="checkbox"/> Working on a computer |
| <input type="checkbox"/> Data entry | <input type="checkbox"/> Memory | <input type="checkbox"/> Repetitive motion | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Operating a mouse | <input type="checkbox"/> Safety is affected | |
| <input type="checkbox"/> Fine visual work | <input type="checkbox"/> Prolonged sitting | <input type="checkbox"/> Shoulder checking | |
| <input type="checkbox"/> Forceful exertion tasks | <input type="checkbox"/> Prolonged standing | <input type="checkbox"/> Speech | |

General Movement Activities:

- | | |
|--|--|
| <input type="checkbox"/> Movements requiring neck strength or motion | <input type="checkbox"/> Movements requiring upper back strength or motion |
| <input type="checkbox"/> Movements requiring mid back strength or motion | <input type="checkbox"/> Movements requiring lower back strength or motion |
| <input type="checkbox"/> Movements requiring hand strength or motion | <input type="checkbox"/> Movements requiring wrist strength or motion |
| <input type="checkbox"/> Movements requiring elbow strength or motion | <input type="checkbox"/> Movements requiring shoulder strength or motion |
| <input type="checkbox"/> Movements requiring hip strength or motion | <input type="checkbox"/> Movements requiring knee strength or motion |
| <input type="checkbox"/> Movements requiring ankle strength or motion | <input type="checkbox"/> Movements requiring foot strength or motion |

Motor Vehicle Accident Health History Form (Page 5):

Oswestry Disability:

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We do realize that two or more options may apply, but please only select one. Thank you

Section 1: Pain Intensity

I have no pain at the moment The pain is very mild at the moment The pain is moderate at the moment
 The pain is fairly severe at the moment The pain is very severe at the moment
 The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. Washing, dressing)

I can look after myself normally without causing extra pain I can look after myself normally but it causes extra pain
 It is painful to look after myself and I am slow and careful I need some help but can manage most of my personal care
 I need help everyday in most aspects of self-care I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

I can lift heavy weights without extra pain I can lift heavy weights but it gives me extra pain
 Pain prevents me from lifting heavy objects off of the floor, but if it conveniently placed (eg. table)
 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
 I can only lift very light weights I cannot lift anything

Section 4: Walking

Pain does not prevent me from walking any distance Pain prevents me from walking more than 2 miles
 Pain prevents me from walking more than 1 mile Pain prevents me from walking more than a mile
 I can only walk using a stick or crutches I am in bed most of the time, and try to avoid walking

Section 5: Sitting

I can sit in any chair for as long as I would like without any extra pain I can only sit in my favorite chair for as long as I would like
 Pain prevents me from sitting for more than one hour Pain prevents me from sitting for more than 30 minutes
 Pain prevents me from sitting for more than 10 minutes Pain prevents me from sitting at all

Section 6: Standing

I can stand for as long as I would like without any extra pain I can stand for as long as I like but it gives me extra pain
 Pain prevents me from standing for more than one hour Pain prevents me from standing for more than 30 minutes
 Pain prevents me from standing for more than 10 minutes Pain prevents me from standing at all

Section 7: Sleeping

My sleep is never disturbed My sleep is occasionally disturbed by pain Because of my pain I have less than 6 hours of sleep
 Because of my pain I have less than 4 hours of sleep
 Because of my pain I have less than 2 hours of sleep Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

My sex life is normal and causes no extra pain My sex life is normal but cause some extra

Motor Vehicle Accident Health History Form (Page 6):

pain My sex life is nearly normal but is very painful My sex life is severely restricted
because of pain My sex life is nearly absent because of pain Pain prevents any sex life at
all

Section 9: Social Life

My social life is normal and causes no extra pain My social life is normal but cause some
extra pain Pain has no significant effect on my social life apart from limiting my energetic
interests (e.g. sports) Pain has restricted my social life and I do not go out as often Pain
has restricted my social life to home I have no social life because of pain

Section 10: Travelling

I can travel anywhere without any pain I can travel anywhere but it gives me extra pain
Pain is bad but I manage journeys over 2 hours Pain restricts me to journeys over 1 hour
Pain restricts me to short necessary journeys under 30 minutes Pain prevents me from
traveling except to receive treatment

Thank you for taking the time to fill out this MVA history questionnaire. This information is important in the doctor obtaining a clinical picture so as to make an appropriate diagnosis & treatment plan. Please sign below authorizing that the information in this form has been read & filled out completely & accurately to the best of your understanding. Also, understand that the information in this form is considered confidential & for use by your doctor at Neurological Rehabilitation Center LLC. Any disclosure is outlined in our privacy policies.

_____ Patient's signature (or guardian's signature)

_____ Date

_____ Signature of translator or person assisting with this form (if any)

Printed name of said person _____ Date