Motor Vehicle Accident - Patient Data Form - MVA/PDF

Patient Information Date _____

Patient Name _____
Last Name First Name Middle Name

Sex ☐Male ☐ Female Date of Birth _____ Age _____ SS# _____

Street Address _____ Apt _____

City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Other _____

☐ Single ☐ Married ☐ Partner for _____ years ☐ Separated ☐ Divorced ☐ Widowed

☐ Student ☐ Not Employed ☐ Employed Part Time ☐ Employed Full Time ☐ Retired

Occupation _____ Employer/ School _____

Address _____

Education _____

How did you hear about us? _____

Spouse/ Parent/ Guardian/ or Significant Other _____

Work Phone _____ Home Phone _____

Person to Contact in Case of Emergency _____

Work Phone _____ Home Phone _____

1. Date of Accident: _____ Time: _____
2. Driver of vehicle: _____ Where were you _____
3. Owner of vehicle: _____ Year, make and model: _____
4. What approx. damage was done to the vehicle? $ _____
5. Visibility at time of accident: poor / fair / good / other: _____
6. Road condition at time of accident: icy / rainy / dry / other: _____
7. Where was your vehicle struck: right / left / rear / front / side / other: _____
8. Type of ☐ head on ☐ broad side ☐ rear end ☐ front impact
   ☐ non-collision: _____
9. Describe what happened to you upon _____
10. Did you see the accident Yes No
11. Did you brace for impact? Yes No
12. Were seat belts worn? Yes No
13. Were shoulder harnesses worn? Yes No
14. Was the car braking? Yes No
15. Does your car have headrests? Yes No

    If yes, what was the position of those headrests compared to your head before the accident?
    - ☐ top of headrest was even with bottom of head
    - ☐ top of headrest was even with top of head
    - ☐ top of headrest was even with middle of neck

16. Was your vehicle moving at the time of the Yes No

If yes, how fast were you _____ MPH (estimate)

17. Was there another vehicle involved in the Yes No

If yes, how fast was the other car traveling? _____ MPH (estimate)

18. What was your head / body position at the time of impact:

☐ head turned left/right ☐ body straight in sitting position
☐ head looking back ☐ body rotated left/right
☐ head looking straightforward ☐ other: _____

19. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car:

_____

_____

_____

20. As a result of the accident were ☐ rendered unconscious ☐ dazed, circumstances vague ☐ _____

21. Could you move all of your body parts? Yes No

If no, what parts and why? _____

22. Were you able to get out of the vehicle and walk unaided? Yes No

If no, why not? _____

23. What bleeding cuts did you get from this accident, if any? _____

_____

24. What bruises did you get from this accident, if any? _____

_____

_____

25. Please describe how you felt (please be specific)

Immediately after accident: _____

Later that day: _____

The next day: _____

26. Check symptoms apparent since the accident:

☐ Neck pain/stiffness	☐ Loss of smell	☐ Headaches	☐ Sleeping problems
☐ Mid back pain	☐ Loss of taste	☐ Dizziness	☐ Fatigue
☐ Low back pain	☐ Loss of memory	☐ Cold sweats	☐ Tension
☐ Numbness in toes	☐ Eyes sensitive to light	☐ Fainting	☐ Anxious
☐ Numbness in fingers	☐ Pain behind eyes	☐ Ringing in ears	☐ Irritability
☐ Cold hands	☐ Chest pain	☐ Constipation	☐ Nervousness
☐ Cold feet	☐ Shortness of breath	☐ Diarrhea	☐ Depression

☐ Other: _____

27. Did you go and seek medical attention immediately/soon after the accident? Yes No (if no, skip to #46)

If yes, how did you get there: ☐ Someone else drove me ☐ Ambulance ☐ Drove myself ☐ Police

☐ Other:

---

28. Doctor 1 / Hospital / _____ Date: _____

29. Were you examined? Yes No

30. Were x-rays or other images taken? Yes No

If yes, what kind of images and what areas of the _____

31. What treatment did you receive? ☐ Bed rest ☐ Brace ☐ Physiotherapy ☐ Adjustments ☐

☐ Other: _____

32. What benefits did you receive from the above mentioned treatment?

33. Date of last

34. Doctor 2 / Hospital / Clinic: Date:
35. Were you examined? Yes No
36. Were x-rays or other images taken? Yes No
    If yes, what kind of images and what areas of the body?
37. What treatment did you receive? ☐ Bed rest ☐ Brace ☐ Physiotherapy ☐ Adjustments ☐
    ☐ Other:
38. What benefits did you receive from the above mentioned treatment?

39. Date of last treatment:

40. Doctor 3 / Hospital / Clinic: Date:
41. Were you examined? Yes No
42. Were x-rays or other images taken? Yes No
    If yes, what kind of images and what areas of the body?
43. What treatment did you receive? ☐ Bed rest ☐ Brace ☐ Physiotherapy ☐ Adjustments ☐
    ☐ Other:
44. What benefits did you receive from the above mentioned treatment?

45. Date of last treatment:

46. Occupation Employer:
47. Have you missed time from work due to accident? Yes No
    Full time off work to , to
    Part time off work to , to
    ☐ Been unable to work since the accident.
48. Did you have any physical complaints JUST BEFORE THE ACCIDENT? Yes No
    If yes, please describe in

49. Prior to the accident, have you EVER had symptoms similar to what you are experiencing now? Yes No
    If yes, please explain:
50. Briefly describe past falls, injuries, accidents, operations,

51. Do you notice any activities of your home daily routines that are different now than before the accident? Yes No
    If yes, please list them in the correct category:
    Those you are unable to do:
    Those that are painful to do:
    Those that are difficult to

52. Is there anything else we should know in regards to this

53. Do you have an attorney in this case? Yes No

If yes, please provide their information: Name: _____

Firm Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax: _____

Automobile Accident Insurance Data

54. Patient's Regular Insurance Company Information:

Company Name: _____

Phone #: _____

Policy #: _____

Address: _____

City: _____ State: _____ ZIP: _____

55. Patient's Automobile Insurance Company Information:

Company Name: _____

Phone #: _____ Adjuster Name: _____

Policy #: _____ Claim Number: _____

Address: _____

City: _____ State: _____ ZIP: _____

If your insurance adjuster told you that another insurance company is to be billed directly than please fill out the next

56. Other Insurance Company Information:

Company Name: _____

Phone #: _____ Adjuster Name: _____

Policy #: _____ Claim Number: _____

Address: _____

City: _____ State: _____ ZIP: _____

Neck Index

Patient Name _____ ***Date***_____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain is moderate at the moment.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have slight headaches which come frequently.
③ I have moderate headaches which come infrequently.
④ I have moderate headaches which come frequently.
⑤ I have headaches almost all the time.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Neck Index Score ☐

Back Index

Patient Name _____ ***Date***_____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Personal Care

⓪ I would not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor.
④ Pain prevents me from lifting heavy weights, but I can manage medium weights if they are conveniently positioned.
⑤ I can only lift very light weights at the most.

Walking

⓪ I have no pain when walking.
① I have some pain when walking, but it does not increase with distance.
② I cannot walk more than one mile without increasing pain.
③ I cannot walk more than ½ mile without increasing pain.
④ I cannot walk more than ¼ mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than ½ hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without extra pain.
① I have some pain on standing, but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than ½ hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain, my normal sleep is reduced by less than 25%.
③ Because of pain, my normal sleep is reduced by less than 50%.
④ Because of pain, my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.).
③ Pain has restricted my social life and I do not go out as often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel.
⑤ Pain prevents all forms of travel except that done by lying down.

Changing Degree of Pain

⓪ My pain is rapidly getting better.
① My pain fluctuates, but is definitely getting better.
② My pain seems to be getting better, but improvement is slow at present.
③ My pain is neither getting better nor worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score ☐

ORTMAN®
CHIROPRACTIC CLINIC

PO BOX 157, CANISTOTA, SD 57012
(605) 296-3431 • WWW.ORTMANCLINIC.COM

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION AND IRREVOCABLE ASSIGNMENT

To Whom It May Concern:

I, _____ , understand that I remain personally responsible for the total amounts due to Ortman Chiropractic Clinic for their services. I further understand and agree that this Authorization does not constitute any consideration for Ortman Chiropractic Clinic to await payments and that they may demand payments from me immediately upon rendering services at their option.

I authorize Ortman Chiropractic Clinic to release any information pertinent to my case to any insurance company, including 3rd party payor, adjuster or attorney to facilitate collection under this Authorization. I agree that Ortman Chiropractic Clinic shall be given the Power of Attorney to endorse and/or sign my name on any and all checks for payment of any outstanding bill owed Ortman Chiropractic Clinic.

I further understand and agree, that if Ortman Chiropractic Clinic must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse Ortman Chiropractic Clinic for all costs of such collection efforts, including but not limited to all court costs and all attorney fees. I also understand that interest will be charged on all balances 60 days past due.

I further direct that this Authorization and Assignment shall be binding upon my legal heirs, successors, assignees, legatees or any other party legally acting on my behalf.

Patient's Signature X _____ SS# _____ Date: _____ __

Guardian or Spouse's
Signature Authorizing Care X _____ Date: _____ __

ACTIVITIES OF Daily Living

Patient Name: _____ **Date:** _____

Daily Activities: Effects of Current Conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY				
Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform