MVC Questionnaire

Owens Chiropractic 33650 6th Ave S. Suite 100 Federal Way, WA 98003 (P) 253-942-3300

Name _____ Date _____

Date of Accident: _____

Your Insurance

Claim # _____ Policy # _____

Insurance Company _____

Address _____

Adjuster _____ Phone # _____

Year & Model of your car: _____

Who owns the car?_ _____

Third Party Insurance (The Person That Hit You)

Claim # _____ Policy # _____

Insurance Company _____

Address _____

Adjuster _____ Phone # _____

Driver's name _____ Address _____

Driver of Car: _____

Who owns the car?_ _____

Year & Model of the other car: _____

Time of Accident: _____ AM/PM

Location of Accident: _____

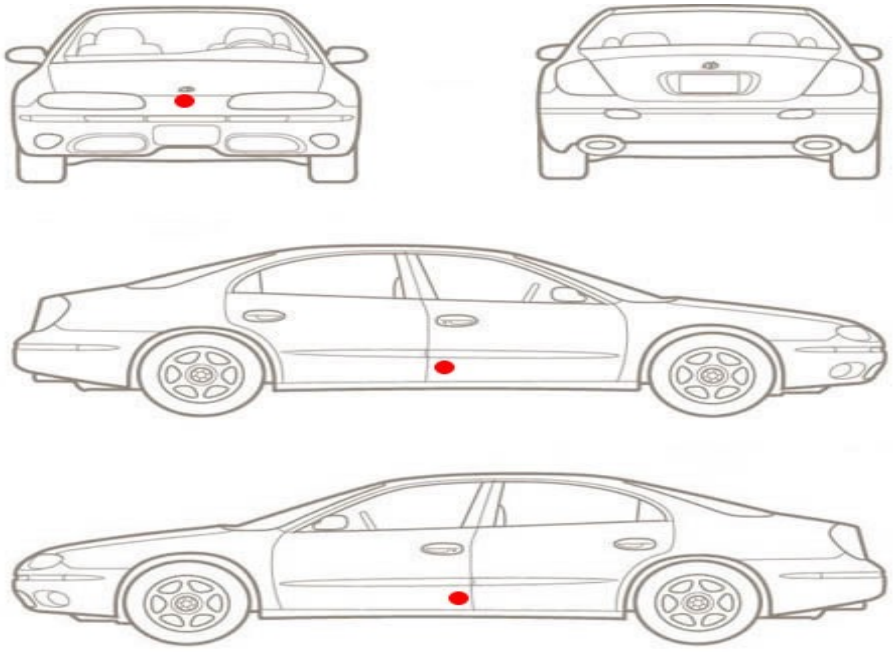
Where were you seated?_____

Visibility at the time of the accident: ☐ good ☐ fair ☐poor ☐ other_____

Road conditions at the time of the accident: ☐ icy ☐ wet ☐ rainy ☐ clear & dry

☐ dark ☐ other (describe): _____

Where was your car struck?



In your own words please describe the accident in detail:

_____

_____

_____

_____

Type of accident: □ broad-side collision □ head-on collision □ front impact
□ rear-end car in front □ rear impact □ non-collision □ other_____

1) At the time of the accident, recall what parts of your head/body hit anything on the inside of car? _____
2) Did you see the accident coming? □ yes □ no
3) Did you brace for the impact? □ yes □ no □ not sure/can't remember
4) Does the vehicle have airbags? □ yes □ no
   If yes, did the airbags deploy? □ yes □ no
5) Were seatbelt's worn? □ yes □ no
6) Were shoulder harnesses worn? □ yes □ no
7) How was the shoulder harness adjusted? □ doesn't apply □ snug □ loose
8) Does the vehicle have headrests? □ yes □ no □ not sure
   - If yes, what was the position of the headrests compared to your head at the time of the accident?
     __ top of headrest even with the **bottom** of head
     __top of headrest even with the **top** of head
     __top of headrest even with the **middle** of head
     __top of headrest even with the **middle** of the neck
     __other: _____
9) Was the car braking at the time of the accident? □ yes □ no
   1. Was your car moving at the time of the accident? □ yes □ no
   2. If yes, how fast would you estimate you were going? _____ mph
   3. How fast would you estimate the other car was going? _____mph
   4. Head/body position at the time of impact:
      □ head turned left/right □ body straight in sitting position
      □ head looking back □ body rotated right/left
      □ head straight forward □ other: _____
   5. As a result of the accident you were: □ in shock □ rendered unconscious
      □ dazed □ circumstances vague □ other: _____

6. If unconscious, how long? _____
7. Were you wearing hat or glasses? (please circle what you were wearing): □ yes □ no
8. Could you move all parts of your body after the accident? □ yes □ no
9. If no, what parts couldn't you move and why? _____
10. Were you able to get out of the car and walk unaided? □ yes □ no
11. If no, why? _____
12. Did you get any bruises? □ yes □ no If yes, where? _____
13. Did you have any bleeding cuts? □ yes □ no If yes, where?_____
14. Please describe how you felt:
    Immediately after the accident: _____
    Later that day: _____
    The next day: _____
15. Check symptoms that have appeared since the accident:

__ Lumbar Pain	__ Rt Shoulder	__Dizziness/ Vertigo
__Thoracic Pain	__Lt Shoulder	__Light Headed
__Cervical Pain	__Rt Elbow	__Forgetful
__Lt Hip	__Lt Elbow	__Anxiety
__Rt Hip	__Rt Elbow	__Depression
__Lt Knee	__Lt Hand	__Irritability
__Rt Knee	__Rt Hand	__Jaw Pain Clicking
__Lt Foot	__Headaches	__Extremity Paresthesia
__Rt Foot	__Migraines	__Extremity Numbness

16. Occupation: _____
17. Employer: _____
18. Have you missed time from work? □ yes □ no
19. If yes, full time off work: _____ to _____
20. If yes, part time off work: _____ to _____
21. Did you seek medical help immediately after the accident? □ yes □ no
22. If yes, how did you get there? □ someone else took me □ police □ ambulance □ drove my own car □ other: _____
23. Doctor # 1 Name: _____
24. First visit date: _____
25. Where X-rays taken? □ yes □ no
26. Did you receive: □ collar □ brace (s) □ medication (s) □ other:_____
27. If yes to medication (s), what did you receive? _____
    _____
28. What benefits did you receive from your visit? _____
29. Date of last treatment? _____
30. Do you have an attorney for this claim? □ yes □ no
31. If yes, who? _____
    Address: _____
    City: _____ State: _____ Zip: _____
    Phone: _____

Activities of Daily Living Assessment

This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check the items in each section which most closely applies to you.

Section 1 Pain Intensity

- ☐ I can tolerate the pain I have without using pain killers.
- ☐ The pain is bad, but I manage without taking pain killers.
- ☐ Pain killers give complete relief from the pain.
- ☐ Pain killers give moderate relief from the pain.
- ☐ Pain killers give very little relief from the pain.
- ☐ Pain killers give no relief from the pain therefore I do not use them.
- ☐ Regardless of the pain, I do not believe in taking pain killers.

Section 2 Personal Care (washing, dressing, etc.)

- ☐ 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 manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, was with difficulty and stay in bed.

Section 3 Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (on a table or at like height).
- ☐ 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 life or carry anything at all.

Section 4 Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk using a cane, walker or crutches.
- ☐ I am in bed most of the time and have to crawl to my destination.

Section 5 Sitting

 I can sit in any chair as long as I like.
 I can only sit in my favorite chair as long as I like.
 I can sit, but am constantly shifting and moving to get comfortable.
 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 as long as I want without extra pain.
 I can stand as long as I want, but it causes 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

 Pain does not prevent me from sleeping well.
 I can sleep well, but only by taking sleeping pills/pain medication.
 Even when I take sleeping pills/pain medication I have less than 6 hours sleep.
 Even when I take sleeping pills/pain medication I have less than 4 hours sleep.
 Even when I take sleeping pills/pain medication I have less than 2 hours sleep.
 Pain prevents me from sleeping at all.
 I do not take sleeping pills/pain medication and can only sleep ____ hours.

Section 8 Sex Life

 My sex life is normal and causes no extra pain.
 My sex life is normal, but causes some extra pain.
 My sex life is nearly normal, but is very painful.
 My sex life if severely restricted by 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 gives me no extra pain.
 My social life is normal, but increases the degree of pain.
 Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc.).
 Pain has restricted my social life and I don't go out as often.
 Pain has restricted my social life to home.
 I have no social life because of the pain.

Section 10 Traveling

 I can travel anywhere without extra 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 a journey of less than one hour.
 Pain restricts me to short, necessary trips under ½ an hour.
 Pain restricts me from traveling except to doctor's appointments or the hospital.