Tranquility
Natural Health

4200 SW Mercantile Dr., Suite 750
Lake Oswego, OR 97035
(503) 305-7762
(503) 387-5148 fax

Motor Vehicle Collision Forms

DATE: _____

Name: _____

Date of Injury: _____ Time: _____ AM / PM

City/County of crash: _____

What were the road conditions at the time of the crash? (icy, dry, wet, fog, dry, etc.) _____

_____

Who owns the vehicle you were in? _____

What's the estimated damage to your vehicle? $_____ By whom? _____

Did the police come to the scene? Y / N Was a report made? Y / N

Were pictures taken of the vehicle or scene? Y / N

Describe how the crash happened: _____

_____

_____

_____

_____

Collision Type (check all that apply)

_____ Single car crash	_____ Rollover	_____ Side crash (T-bone)
_____ Two vehicle crash	_____ Rearend	_____ Run off road
_____ Three or more	_____ Head-on	_____ Hit guard rail, tree, or other object

_____ Other _____

Indicate where you were positioned: Driver Passenger (position): _____

Describe the vehicle you were in:(make, model, year) _____

_____ Mini	_____ 2 door	_____ Hatchback
_____ Small/compact	_____ 4 door	_____ SUV
_____ Mid size	_____ Pick up	_____ Wagon
_____ Large sedan	_____ Van	_____ Large truck, bus, or semi-truck

Describe the other vehicle:(make, model, year if known) _____

_____ Mini	_____ 2 door	_____ Hatchback
_____ Small/compact	_____ 4 door	_____ SUV
_____ Mid size	_____ Pick up	_____ Wagon
_____ Large sedan	_____ Van	_____ Large truck, bus, or semi-truck

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Motor Vehicle Collision Forms

Name: _____ MVC P2

At the time of the impact, your vehicle was:

_____ Stopped _____ Slowing down

_____ At a steady speed _____ Gaining speed

At the time of impact, the other car was:

_____ Stopped _____ Slowing down

_____ At a steady speed _____ Gaining speed

_____ Unknown _____ Other _____

During and/or after the crash, your vehicle:

_____ Kept going straight, not hitting anything _____ Was hit by another vehicle

_____ Kept going straight, hitting the car in front _____ Spun around, not hitting anything

_____ Spun around, hitting object other than car _____ Spun around, hitting another car

Did any part of your body make contact with any of the following? Please indicate body part next to object: (head, face, shoulder, arm/hand. Front chest, side chest, hip, abdomen, knee, leg, foot)

Windshield or side window _____

Steering wheel _____

Side of door _____

Dashboard _____

Knee bolster/ glove compartment _____

Seatbelt (lap belt or shoulder harness) _____

Frame of car near windows _____

Roof or top part of vehicle _____

Another occupant/animal _____

Other _____

Check if any of the following were damaged, broken, bent in your car after the crash:

_____ Windshield _____ Seat frame _____ Rear window

_____ Steering wheel _____ Window _____ Other _____

_____ Dash _____ Mirror _____ Other _____

Y / N Did any of the interior front or side structures, such as the side door, dash, steering wheel, or floorboard of your car dent inward during the crash?

Y / N Did the side door touch your body during the crash?

Y / N Did your body slide under the seatbelt?

Y / N Was the door(s) of your vehicle damaged to thepoint you could not open the door?

Y / N Did your airbags deploy? (If your car does not have airbags, please indicate:_____)

Y / N Did you have any areas of bruising after the crash? Where? _____

Y / N Were you intoxicated or under the influence of a substance at the time of the crash?

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Motor Vehicle Collision Forms

MVC P3

Name: _____

Y / N Were you wearing a seatbelt? If yes, was it a ____lap & shoulder strap, or ____ Lapbelt only

Y / N Did you ave any portion of your seatbelt positioned behind your chest, back or shoulder?

Y / N Were you holding onto the steering wheel (driver only) at the time of impact?

If yes, indicate where your hands were positioned at the time, using clock face for reference

Right hand _____not on the wheel -or- _____o'clock

Left hand _____not on the wheel -or- _____o'clock

If not on the wheel, please indicate location _____

For rear-end collisions only: **answer only if you were hit from the rear**

Describe your vehicle's head restraint system:

_____ Movable/adjustable head rest _____ Fixed, non movable headrest

_____ No headrest _____ Bench seat without head rest

Please indicate how your head restraint was positioned at the time of the crash:

_____ In line with the top of the head _____ Midway of the height of the head

_____ In line with the lower edge of head _____ Located at the level of the neck

_____ Level with the shoulders/base of the neck

Awareness and Body Positioning:

Y / N I was unaware of the impending collision. I did not see or hear brakes prior to impact.

Y / N I was aware of eht impending crash and relaxed before impact.

Y / N I was aware of the impending crash and braced before impact.

Y / N My body, torso and head were facing straight ahead.

Y / N My body, torso and head were turned at the time of impact.

_____ Turned left _____ Turned right Describe how far and what you were doing:

_____

_____

Y / N I was leaning forward at the time of impact resulting in a gap between my body and the seatback. If yes, how far and why? _____

_____

Y / N My torso and body were positioned normally against the seatback with no gaps, no leaning, and no twisting.

What was your initial reaction immediately after the crash? _____

_____

_____

When did you first notice symptoms after the crash, and what were they? _____

_____

_____

_____

_____

Did you go to ER or doctor? _____ Were X-rays/CT taken? Y / N

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Motor Vehicle Collision Forms

Name: _____ MVC P4

Please check any symptoms you have had since your injury. (Concussion Questionaire)

_____ Headaches
_____ Loss of coordination
_____ Reduced drive/motivation
_____ Poor memory
_____ Difficulty finishing tasks
_____ Sleep disorders
_____ Abnormal levels of anxiety
_____ Reduced tolerance to alcohol
_____ More assertive
_____ Forgetful
_____ Anger outbursts
_____ Depression
_____ Fatigue
_____ Absence of ability to anticipate
_____ Inflexibility
_____ Impaired sexual function
_____ Language difficulty
_____ Impaired judgment
_____ Need to write down all home and/or work activities
_____ Blurry vision
_____ Loss of balance
_____ Difficulty handling multiple tasks
_____ Dizziness/lightheadedness
_____ Irritability
_____ Personality change
_____ Hand tremors
_____ Ringing in the ears
_____ Less diplomatic than normal, or blurting out
_____ Mood swings
_____ Reduced attention span
_____ Blackouts
_____ Indifference to other people
_____ More shallow relationships
_____ Difficulty with problem solving
_____ Less mental stamina
_____ Performance inconsistencies
_____ Verbal learning problems
_____ Slower reaction times

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Motor Vehicle Collision Forms

Name: _____ MVC P5

Please check any symptoms you have had after the crash or before, noting the time the symptoms began. If you haven't had that symptom ever or in more than a year, please leave that section blank.

Symptoms	Began immediately after crash	Began within 24 hours after crash	Began within a week of the crash	Had symptoms in past year (before the crash)	Had symptoms before crash (in past year), but now worse
Headache					
Migraine					
Tinnitus (ringing in the ear)					
Blurry vision					
Memory problems					
Poor concentration					
Irritability					
Balance problems					
Loss of coordination					
Sensitivity to sound					
Sensitivity to light					
Fatigue					
Anxiety					
Pain/difficulty swallowing					
Jaw pain/soreness					
Neck pain/soreness/aching					
Neck stiffness					
Shoulder pain/stiffness					
Arm pain/tingling/numbness					
Wrist/hand/finger pain/numb					
Weakness in arms/legs					
Upper/middle back pain/sore					
Rib cage pain					
Low back pain/sore/aching					
Hip pain					
Leg pain					
Leg numbness/tingling					
Pain shoots down back of legs					
Pain primarily in front of thigh					
Knee pain					
Ankle/foot pain					
Other					

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Motor Vehicle Collision Forms

Name: _____ MVC P6

Please indicate your level of symptoms in each area in the chart below by circling the most appropriate number, where '0' is no pain, and '10' is the worst pain imaginable.

Pain intensity	None	Minimal Discomfort/Ache/Stiff			Slight to moderate Hurts/Sore/Bearable				Severe Sharp/Intense Pain/Unbearable		
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand	0	1	2	3	4	5	6	7	8	9	10
Mid back	0	1	2	3	4	5	6	7	8	9	10
Low back	0	1	2	3	4	5	6	7	8	9	10
Leg/Foot	0	1	2	3	4	5	6	7	8	9	10

Please indicate how frequently you have symptoms such as pain, numbness, tingling, etc.

Symptom Frequency	None	Occasional			Intermittent			Frequent		Constantly	
Headache	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Neck	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/Hand	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid back	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low back	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Judging from the past week, or since the accident/injury if less than a week ago, indicate how frequently you have had headaches and/or migraines. Be sure to indicate how long each headache typically lasts.

_____ No headache
_____ Once a month
_____ Twice a month
_____ Once a week
_____ Twice a week
_____ Three times a week
_____ 4 times a week
_____ 5 times a week
_____ Daily/almost daily

How long does your typical headache/migraine last? _____

Patient Signature: _____ Date: _____

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Motor Vehicle Collision Forms

Name: _____ Date: _____

Personal limitations since the injury:

Social limitations since the injury:

Work limitations since the injury:

Signature: _____