MOTOR VEHICLE ACCIDENT INTAKE
ROOTS WELLCARE, P.A.

Name_____ Date_____
Date of Accident_____

History of Accident
Were you a driver, passenger, or pedestrian?_____
If you were the driver, were other passengers with you?_____
What type of vehicle were you in? (sedan, truck, motorcycle, etc)_____
Were you wearing a seat belt? Yes☐ No☐
Did your body strike any object? Yes☐ No☐ If yes, what?_____

How did the accident occur?_____

_____

_____

What did your body experience during the accident?_____

_____

Did you feel any pain immediately following the accident? Yes☐ No☐ If yes, in which areas? _____

_____

Did police come to the scene and do a report? Yes☐ No☐

Early treatment: at scene of accident, and at hospital
Were you examined at the scene? Yes☐ No☐
If yes, by whom?_____
Did the examiner make any comments? Please state comments._____
_____
Did you lose consciousness? Yes☐ No☐
Were you taken to the hospital? Yes☐ No☐
If yes, which hospital?_____
Were x-rays, CT or MRI taken?_____
Were you transported on a back board to the hospital? Yes☐ No☐ Not sure☐
Was a diagnosis given? Yes☐ No☐ Describe:_____
Treatment received_____
Results of treatment_____
Please describe any recommendations given to you regarding home care or follow-up care:_____
_____

Other Treatment for Accident: (other than hospitalization discussed above)
Where seen?_____
Doctor(s) names_____
Diagnosis_____
Describe treatment received_____
Results of treatment_____

Please describe your symptoms below:

Body area	**Immediately after accident**	**Currently**
Head	_____	_____
Neck	_____	_____
Shoulders	_____	_____
Arms/hands	_____	_____
Upper back	_____	_____
Midback	_____	_____
Lower back	_____	_____
Hips/Pelvis	_____	_____
Legs	_____	_____
Feet	_____	_____
Whole body*	_____	_____

*Includes fatigue, confusion, visual difficulties, hearing problems, swallowing, bladder, bowel movements, or breathing difficulties

Disability
Did you miss work? Yes☐ No☐
If yes, which dates were missed?_____
Which **work-related** activities do you presently find difficult, painful or impossible to do? Why?
_____
_____
Which **home or recreational** activities do you presently find difficult, painful or impossible to do? Why?
_____
_____

Past History
Is there any history of injury or surgery, especially related to the above areas? Please describe.
_____
Is this pain the same, or different?_____
If different, how is it different?_____
Current medications and dosages_____
_____
Other injuries of any type?_____
_____

Legal Representation
Have you retained an attorney? Yes☐ No☐ Name/Phone_____