MVA INITIAL REPORT

Patient Name:				Date:
Date of Injury:				Time of Accident: AM/PM
Road/Weather Condition: ☐Wet ☐Raining ☐Foggy ☐Dry ☐Sunny ☐Cloudy ☐Partly Cloudy ☐ Icy ☐Snow(ing)				
			Please check the appropriate answer in the column to your left to the following questions	
☐Yes	☐No		Was a police report filed?	
☐Yes	☐No		If yes, may we have a copy?	
☐Yes	☐No		Were there drugs or alcohol involved. If yes, please explain.	
	MPH		Approximately how fast was your vehicle going when the impact occurred?	
	MPH		Approximately how fast was the other vehicle going when the impact occurred?	
☐Driver	☐Passenger		Were you the driver or a passenger of the vehicle?	
☐Front	☐Back		If you were the passenger, where were you sitting?	
☐Left	☐Right	☐Middle	If backseat, which position?	
☐Molded	☐Adjust	☐Unsure	Is the head rest part of a molded seat or adjustable?	
☐Yes	☐No	☐Unsure	If adjustable, were they in the proper position?	
☐Yes	☐No		Were you wearing your seatbelt and shoulder harness?	
Vehicle A (your vehicle) List the Year, Make and Model below			Vehicle B or Object B-List Year, Make & Model or Object Involved	Vehicle C or Object C- List Year, Make & Model or Object Involved
☐Automatic	☐Manual		Is your vehicle an automatic or manual transmission?	
☐Yes	☐No	☐Unsure	Is your vehicle equipped with airbags?	
☐Front	☐Side	☐Both	If yes, both front and side airbags, or front only?	
☐Yes	☐No		Did the airbags inflate?	
☐Yes	☐No		Was there a secondary impact? For example, after being hit from behind you were pushed into the car in front of you. If yes, complete information for Vehicle or object C above.	
☐Yes	☐No		Did your vehicle go spin in a different direction than originally headed?	
☐Clockwise	☐Counter-Clockwise		If yes, what direction? Clockwise (driver's right) or Counter Clockwise (driver's left)	
☐Yes	☐No		Did your vehicle roll over?	
☐Yes	☐No		Did you know you were going to be hit?	
Where were your feet on impact?				
Where were your arms on impact?				
Where were you looking on impact?				
How was your body positioned on impact?				
☐Yes	☐No	Has this injury kept you from doing your normal day to day activities?		
☐Yes	☐No	Did you have a job when this accident occurred?		
☐Yes	☐No	Are you currently still working at this job?		
☐Yes	☐No	Have you missed any time from work due to this injury?		

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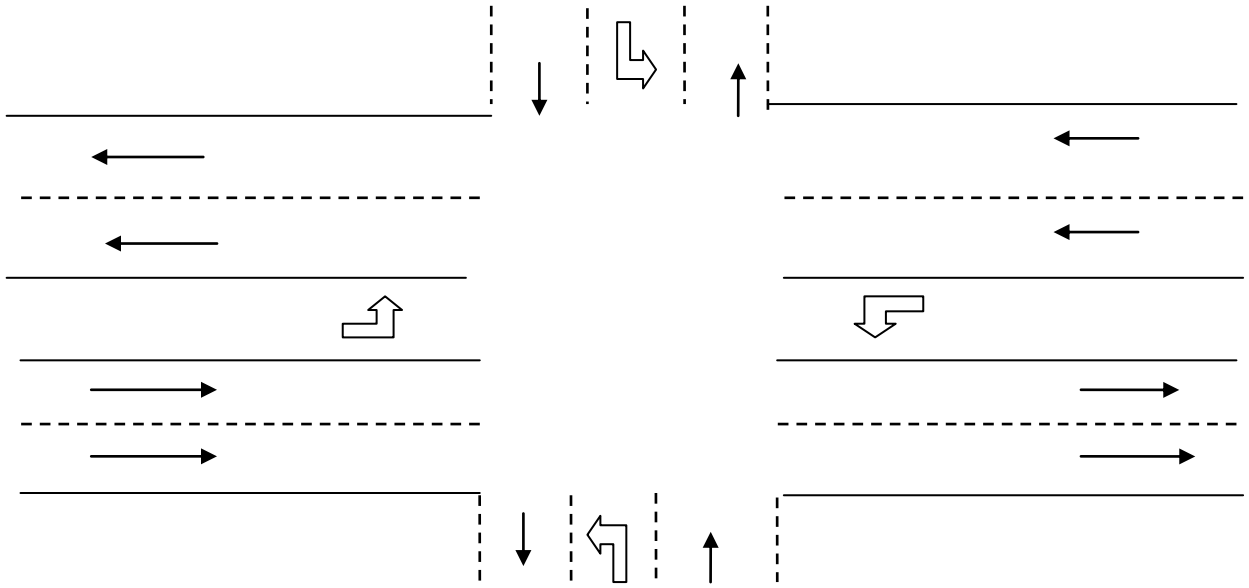
Draw a picture of how the accident happened. Label your car "A", and the other persons car or object "B". Use an "X" to show the impact point on your vehicle. To show where you were in the car mark the spot with an "M"



☐Yes	☐No	Were you seen at the Emergency Room or by another Physician/Chiropractor for the accident? If yes, please list Physician/Chiropractor, Emergency Room name and City and State, where you were seen.
☐Yes	☐No	Did you have any testing done? If yes, describe.
☐Yes	☐No	Did you receive any treatments or medications? If yes, please describe.

Mark with an "X" where you hurt immediately (1-2 days later) following the accident	Mark with an "X" where you hurt today.