Heart Spring Health

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# Motor Vehicle Collision (MVC) Intake

Name: _____ Date: _____

**Accident Information**

Date of Accident: _____ Time of Accident: _____ Were you the ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

Please describe the accident in your own words: _____

_____

Make and model of the vehicle you were in: _____

What speed were you traveling? _____ What speed was the other car traveling? _____

At the time of the impact, where were you looking? _____

Did any part of your body strike anything in the vehicle? ☐ No ☐ Yes _____

The impact was from the ☐Front ☐ Rear ☐Left ☐ Right ☐ Other _____

| | | | | | |
|---|---|---|---|---|---|
| Were both hands on the steering wheel? | ☐ Yes | ☐ No | If no, which was on the wheel? | ☐ L | ☐ R |
| Was your foot on the break? | ☐ Yes | ☐ No | If yes, which foot was on the break? | ☐ L | ☐ R |
| Did your car impact another car? | ☐ Yes | ☐ No | Did your car impact a structure? | ☐ Yes | ☐ No |
| Was the vehicle equipped with airbags? | ☐ Yes | ☐ No | If yes, did they inflate properly? | ☐ Yes | ☐ No |
| Were you wearing a seatbelt? | ☐ Yes | ☐ No | If so, what type? | ☐ Lap | ☐ Shoulder |
| Did the vehicle have a headrest? | ☐ Yes | ☐ No | If yes, what position was it in? | ☐ Low | ☐Mid ☐ High |

Were you ☐ Surprised by the impact ☐ Braced for impact?

Driving conditions: ☐ Dry ☐ Wet ☐ Icy ☐ Other

**Client Condition**

Were you unconscious immediately after the accident? ☐ Yes ☐ No

Please describe how you felt immediately after the accident: _____

**Treatment**

Did you go to the hospital (urgent care)? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No MRI? ☐Yes ☐ No

When did you go? ☐ immediately after the accident ☐ the next day ☐ 2 days or more after

Diagnosis: _____ Treatment received: _____

**Symptoms and/or Injuries**

Have you been able to work since the injury? ☐ Yes ☐ No

Has this injury influenced your work performance? ☐ Yes ☐ No If yes, how? _____