

**MOTOR VEHICLE ACCIDENT INTAKE
ROOTS WELLCARE, PA**

Name _____ Date _____

Date of Accident _____

History of Accident

Were you a driver, passenger, or pedestrian? _____

Were you wearing a seat belt? Yes _____ No _____ Not applicable _____

Did you 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? 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. _____

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 _____

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	_____	_____
Mid Back	_____	_____
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 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? _____

Medications and dosage _____

Other injuries of any type _____

Legal Representation

Have you retained an attorney? _____ Name/phone _____