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MOTOR VEHICLE ACCIDENT (MVA) INTAKE FORM

Note: If this is your first appointment please also fill out a regular (non-MVA) acupuncture initial intake form as well.

Name: _____ Date: ____/____/____

Date of accident: ____/____/____ State where MVA occurred: _____

Please describe the accident in your own words: _____

_____

_____

_____

_____

Were you the (circle): Driver Pedestrian Front Passenger Rear Passenger Bicyclist

Did your airbags inflate: Yes No Were you wearing: Seatbelt Helmet

Did your car or bicycle impact another Vehicle? Yes No Structure? Yes No

Was impact from: Front Back Left Right Other

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

If yes, please explain: _____

_____

At the time of the impact were you looking: Left Right Straight Down Up

Were you: Surprised by the impact Braced for the impact

Have you received medical and/or therapeutic treatment as a result of your injury? Yes No Please describe: (emergency, medical, acupuncture, chiropractic)

_____

_____

_____

Please check anything you have felt since the accident:

- Arm/shoulder pain
- Back pain
- Back stiffness
- Chest pain
- Confusion/fogginess
- Dizziness
- Ear ringing
- Fatigue
- Fear/nervousness
- Feet/toe numbness
- Hand/finger numbness
- Headaches
- Jaw problems
- Leg pain
- Memory loss
- Nausea
- Neck pain
- Neck stiffness
- Nursing difficulty
- Shortness of breath
- Sleep difficulty
- Tension
- Vision blurred
- Other:

Is your condition getting worse? _____ If so, how? _____

_____

What aggravates your condition (sitting, standing, lifting, lying down, etc..) _____

_____

_____

Anything else? _____

- - - -

Auto Insurance Company: _____

Address for claims: _____

Phone number:_____

Claim Number: _____