

MVA Intake Form

Tigges Chiropractic and Wellness

(Fill out completely; if does not apply put N/A.)

Patient Name: _____ Today's Date _____
Date of collision: ___/___/___/ Time: _____ AM / PM
Where did the collision occur? City/Town: _____ State: _____

Please describe the collision in your own words.

Were you the: Driver Passenger Pedestrian
Were you wearing a seat belt? Yes No
Does your vehicle have an airbag? Yes No Did it deploy? Yes No
What type of vehicle were you in? _____
What type was the other vehicle? _____
Was there a second impact? If so, explain. _____

Was the impact from: Front Rear Left Side Right Side
What was the approximate speed at the time of impact? Your Vehicle _____ mph
Other Vehicle _____ mph
Were you going forward backward turning left turning right stopped
Were you surprised by the impact? Yes No
How much damage was there to the outside of your vehicle? None Some Major
To the outside of the other vehicle? None Some Major
Immediately after the accident, where did you experience pain? Be specific: _____

Immediately after the accident were you: conscious dazed unconscious
If dazed or unconscious, how long? _____
Did you strike your head? Yes No
How did you get out of the vehicle? On your own Helped out Taken out by someone
Did you go to the hospital? yes no If yes, how did you get there? _____
If you went to the hospital or saw another doctor, please answer the following?
Hospital Name _____ Doctor Name _____
Diagnosis _____
Treatment received _____
Tests _____

Were you admitted to the hospital? Yes No How long was your stay? _____
Were you dismissed from the ER? Yes No
Have you retained an attorney? Yes No Litigation? Yes No Maybe

What are your current symptoms? Please be as specific as possible.
