energy
health clinic*

Phone: 250-391-8811
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Web: www.energyhealth.ca

Motor Vehicle Accident Initial Consultation

Name: _____ Date: _____

PLEASE COMPLETE ALL INFORMATION

Date of Accident: _____

Were you the driver or the passenger of the vehicle? ☐ Driver ☐ Passenger (front or back)
Were you wearing a seat belt? ☐ Yes ☐ No
Was the vehicle moving or stopped when it was hit? ☐ Moving ☐ Stopped
What were you attempting to do at the time of impact? (Eg. Making a left/right hand turn, changing lanes…)

_____

_____

Did you see the vehicle coming towards you as the collision occurred (did you brace yourself for the impact?)

_____

_____

How was the vehicle struck? (Eg. Rear-end, Head On, Side) _____
Were the airbags activated? ☐ Yes ☐ No
Did your head strike the windshield, side window, or did your chest strike the steering wheel? Explain _____

_____

_____

Were you wearing glasses or a hat at the time of the accident? ☐ Yes ☐ No
If yes, did the impact throw them off? ☐ Yes ☐ No
Did you have any cuts / bruises / stitches? (Describe where?) _____

_____

_____

How did you react to the accident? _____

_____

Were you able to get out of the car? ☐ Yes ☐ No Were you knocked unconscious? ☐ Yes ☐ No
Were you able to get out of the car on your own? ☐ Yes ☐ No
Were you taken to the hospital? ☐ Yes ☐ No If yes, how? ☐ Ambulance ☐ Other Means
Did they use a stretcher? ☐ Yes ☐ No Did they use a neck brace? ☐ Yes ☐ No
Was your car drivable following the accident? ☐ Yes ☐ No
How long did it take following the accident before you felt the pain? _____
Where did you feel the pain? _____

_____

Rate your pain on a scale of 1 to 10. (1=Mild 10=Severe)

1 2 3 4 5 6 7 8 9 10

What type of pain is it?
☐ Burning ☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing

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☐ Tingling ☐ Numbness ☐ Shooting ☐ Cramps ☐ Stiffness
☐ Swelling ☐ Other_____

Who did you consult after the accident (Eg. Chiropractor, Physiotherapist, Medical Doctor...) before coming into our office? _____

What kind of treatments or medication did you receive from them? _____

What other changes have you noticed since the accident?

- ☐ Difficulty Sleeping (number of hours now ____ number of hours before the accident _____)
- ☐ Muscle Tension / Spasms (where?)_____
- ☐ Digestive Problems (explain) _____
- ☐ Headaches (how often?) _____
- ☐ Stiffness (where? is it constant or worse at certain times?) _____
- ☐ Limited Movements (of what body parts?)_____
- ☐ Decreased Appetite
- ☐ Irritable
- ☐ Memory Problems
- ☐ Ringing in the Ears
- ☐ Fatigue
- ☐ Visual Disturbances

List any other changes that are not mentioned: _____

_____

Has this problem prevented you from doing anything (going to work, hobbies, activities, sleeping, sitting, standing, walking, life in general, etc...)? Describe how these activities of daily living have been affected? Please list ***anything*** that you ***can't*** do now that you ***used to be able to do*** with ease and explain ***why*** you can't do these activities now. (Eg. Too much pain, fatigue, headaches...) _____

_____

_____

_____

_____

_____

Which activities are difficult to perform?

☐ Sitting ☐ Standing ☐ Walking ☐ Bending
☐ Lying Down ☐ Reaching Up ☐ Picking things up from the floor

Have you ever broken any bones or torn ligaments in the past? ☐ Yes ☐ No
If yes, specify: _____

Have you ever injured the present area of pain in your body in the past? ☐ Yes ☐ No
If yes, specify: _____

Have you ever been a recipient of Workers' Compensation Benefits? ☐ Yes ☐ No
If yes, specify type of injury: _____

Have you ever had a previous motor vehicle accident? ☐ Yes ☐ No
If yes, specify what injuries you sustained: _____

Signature: _____