MID-ATLANTIC
BRAIN & NEUROLOGICAL
REHABILITATION

# Motor Vehicle Accident Intake

MABNR 1400 Forest Glen Road, Suite 225 • Silver Spring, MD 20910 • Tel (240)-766-8881 Fax (240)-766-3763 • www.mabnr.com

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Patient Name: _____

Date of accident:_____ Approximate time of accident: _____

## Your Vehicle

What is the make/model of your car/truck? _____Year: _____

Were you the: ☐Driver Front Right Passenger ☐ Front middle passenger ☐ Rear passenger, driver's side ☐ Rear passenger, right side ☐Rear middle passenger Other: _____
At the time of the accident, what kind surface were you driving on? ☐Dry pavement ☐Wet pavement ☐Gravel ☐Dirt Other: _____
Were you restrained by a seatbelt? ☐No ☐Yes If yes, what kind? ☐Shoulder and lap belts ☐Shoulder only ☐Lap only
Did your seat have a headrest? ☐No ☐Yes
Where was the top of the headrest positioned in relation to the top of your head?
☐Above my head ☐Below my head ☐Level with my head
Do you recall how far your headrest was from the back of your head?
☐No ☐0-1 inches ☐1-3 inches ☐3 or more inches

## The Other Vehicle(s)

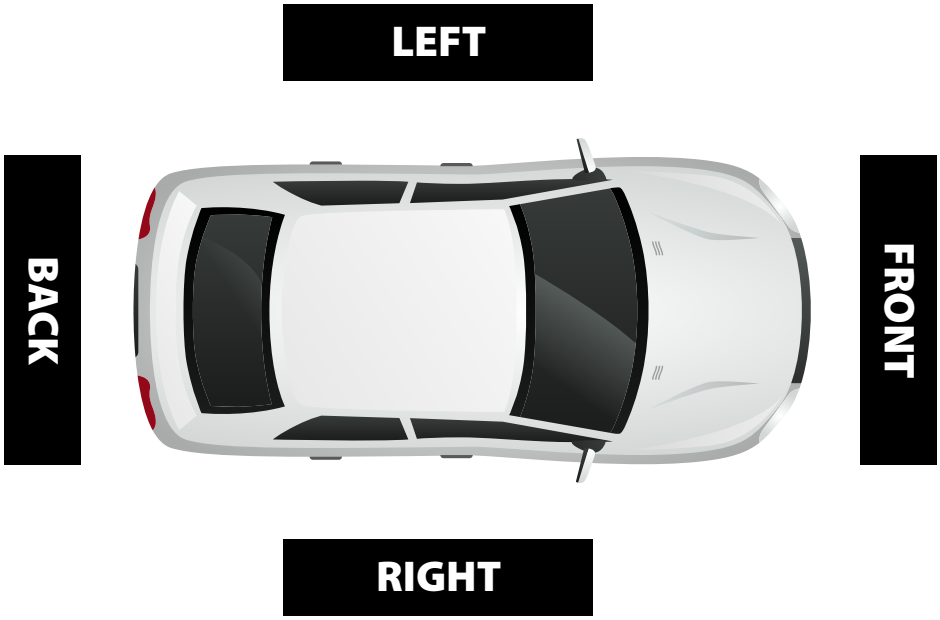
How many vehicles struck your car? _____ If more than one, ask for a piece of paper and answer the questions in this table for each vehicle.
What is the make/model of their car/truck? _____Year: _____
Approximately how fast were you going at the time of impact?_____ mph.
Approximately how fast was the other car going at the time of impact? _____ mph.
About how far did your car move after being struck? _____ feet.

## The Accident

If you were car was standing still at the point of impact, where was your foot or feet?
☐Pressed on the brake ☐Resting on the break

Where was your head facing when the collision occurred? ☐Looking right at rearview mirror ☐Looking right through a window ☐Looking left through a window ☐Looking right through back window ☐Looking up ☐Looking down

## On the diagram to the below, please mark the point(s) of impact on to your vehicle




Which direction did the striking vehicle come from?

☐Head on (from front)
☐From behind
☐From right
☐From left
☐Diagonal or obliquely from:_____
_____
_____

After the accident did you strike anything else? ☐No ☐Yes

If yes, describe: _____
_____
_____
_____

Was there any damage done to your vehicle? ☐No ☐Yes

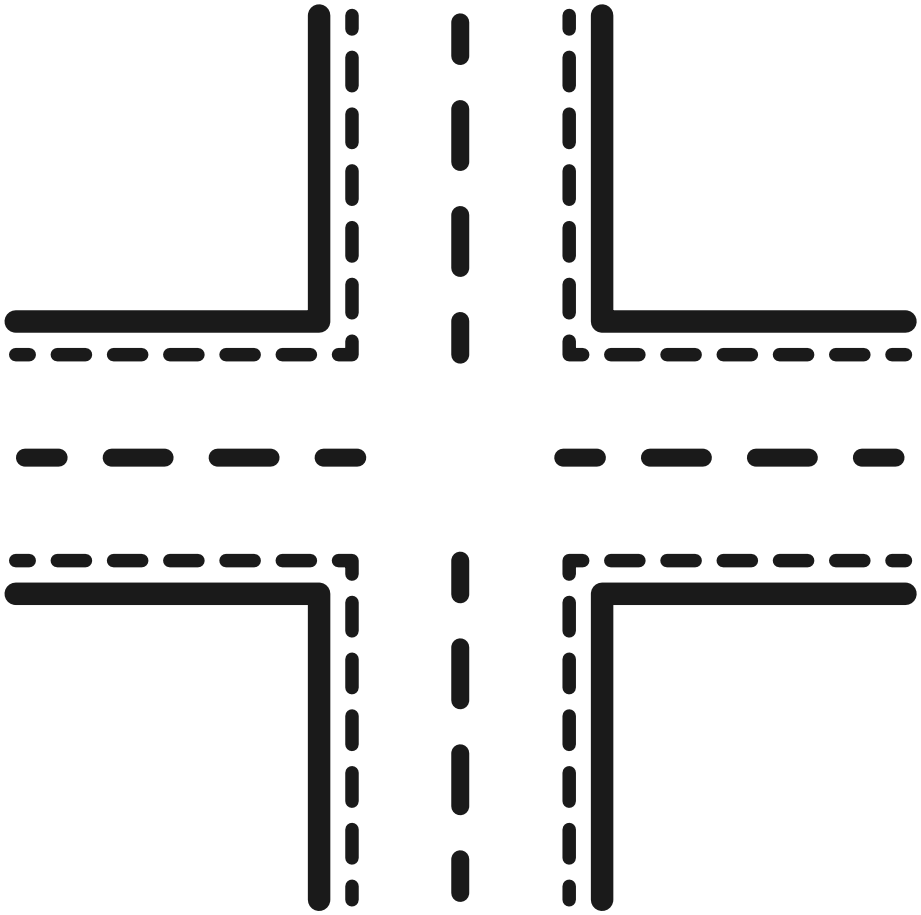
If yes, how extensive: _____
_____
_____
_____

Did your airbags deploy? ☐No ☐Yes If yes, which airbags?_____

Doctor's Notes: _____
_____
_____

Did the police arrive? ☐No ☐Yes If yes, was a report made? ☐No ☐Yes

Below please describe in your words how the accident occurred, use the diagram of an intersection if helpful:



Were you aware of the collision as it occurred? ☐No ☐Yes

Did any part of your body strike the interior of your vehicle? ☐No ☐Yes

Do you have any pain as a result of the collision? ☐No ☐Yes

If yes, then did you brace your arms and legs? ☐No ☐Yes

If yes, explain: _____

_____

_____

_____

If yes, how explain: _____

_____

_____

_____

Did you lose consciousness at any point during or after the collision? ☐No ☐Yes

Did you suffer any bruises, cuts, or broken bones from the collision? ☐No ☐Yes If yes, explain:_____

_____

Doctor's Notes: _____

_____

_____

**Did you suffer any of the following symptoms (check all that apply)?**

☐Dizziness
☐Light headedness
☐Severe headache
☐Vertigo
☐Blurry vision
☐Confusion
☐Memory loss
☐Extreme drowsiness
☐Difficulty with focus or concentration
☐Sensitivity to light
☐Visual disturbances
☐Nausea/Vomiting
☐Muscle weakness
☐Numbness or tingling
☐Ringing in ears
☐Difficulty sleeping
☐Difficulty with speech
☐Feelings of depression or sadness
☐Feelings of nervousness or anxiety
☐Crying for no reason.
Other:_____

## Medical History

Did you go to the hospital after the accident? ☐No ☐Yes If yes, please answer the five questions below:

1. Did you travel by: ☐Ambulance ☐Your car ☐Another car
2. How long after the accident did you arrive at the hospital?
3. How did you leave the hospital? ☐Someone drove me ☐I drove myself
4. Were x-rays or other imaging procedures performed? ☐No ☐Yes
   If yes, explain:_____

5. Did you receive treatment or any prescription/medications at the hospital? ☐No ☐Yes

If yes, explain:_____

Other than the hospital, have you visited any other health care providers since the accident? ☐No ☐Yes
If yes, please explain (include names and numbers):_____
_____
_____
_____

Have you ever been involved in a motor vehicle accident before? ☐No ☐Yes
If yes, please answer the five questions below:

1. When and where did the accidents(s) occur?
*If more than 3, please use another sheet of paper*
a. _____
b. _____
c. _____

2. Who did you see for care?
*If more than 3, please use another sheet of paper*
a. _____
b. _____
c. _____

3. What type of care did you receive?
*If more than 3, please use another sheet of paper*
a. _____
b. _____
c. _____

Did all of your symptoms resolve from the above mentioned accident(s)? ☐No ☐Yes
If not, what symptoms persisted? _____

Did any remaining symptoms affect your daily activities in any way? ☐No ☐Yes.
If yes, explain:_____

# Motor Vehicle Accident Health History

Please mark the activities below that have been adversely affected , or are difficult to perform, since your motor vehicle accident.

## Domestic Activities

| | | | |
|---|---|---|---|
| Cleaning | Folding laundry | Moving items | Standing |
| Cooking | Getting into/out of bed | Lifting objects | Vacuuming |
| | Holding bowls or cups | Sitting down | Other:_____ |

## Personal Care Activities

Combing hair
Brushing teeth
Applying makeup
Nail care
Showering
Shampooing hair
Toilet care
Bathing
Dressing
Shaving
Eating
Other:_____

## Relationship Activities

Hugging
Kissing
Laughing
Holding Hands
Sexual Activities
Personal Relationships
Other:_____

## Child Care Activities

Carrying your child
Changing diapers
Entertaining your child
Bathing your child
Breast feeding
Bottle feeding
Rocking your child
Packing lunch
Picking up your child
Playing with your child
Hugging your child
Pushing a stroller
Toweling after bath
Other:_____

## Sports & Athletic Activities

Aerobics
Archery
Baseball
Badminton
Basketball
Biking
Boogie boarding
Bowling
Camping
Canoeing
Cross country skiing
Down hill skiing
Football
Golf
Gymnastics
Handball
Horseback riding
Hunting
Ice skating
Jet skiing
Jogging
Martial arts
Mountain biking
Pilates
Racquet sports
Rafting
Rollerblading
Rock climbing
Roller skating
Rugby
Soccer
Softball
Snowmobiling
Snowboarding
Surfing
Swimming
Table tennis
Tennis
Walking
Waterskiing
Weight training
Wind surfing
Working out
Wrestling
Volleyball
Yoga
Other:_____

## Social Activities

Religious practices
Picnics
Sightseeing
Visiting friends/relatives
Movies
Eating out
Entertaining
Vacationing
Shopping
Music events / concerts
Dancing
Walking
Going out
Reading
Other:_____

## General Household Activities

Mowing the lawn
Fertilizing
Tree trimming
Watering the lawn
Weeding
Yard work
Clearing brush
Raking
Cleaning the gutters
Spraying
Car maintenance
Washing car
Using tools
Painting
Hammering

## Activities that Impact Your Career

Attendance at work
Performance at work
Bending activities
Bookkeeping
Communication
Concentration
Data entry
Driving
Fine visual work
Forceful exertion tasks
Grasping actions
Group tasks
Heavy work
Keyboarding
Lifting objects
Machine operation
Memory
Operating a mouse
Prolonged sitting
Prolonged standing
Prolonged walking
Performing required tasks
Pushing actions
Pulling actions
Reaching actions
Reading
Repetitive motion
Safety is affected
Hiking
Speech
Stairs
Telephone operation
Tool operation
Transportation to work
Writing
Working on a computer
Other:_____

## General Movement Activities

Movements requiring neck strength or motion
Movements requiring mid back strength or motion
Movements requiring hand strength or motion
Movements requiring elbow strength or motion
Movements requiring hip strength or motion
Movements requiring ankle strength or motion
Movements requiring upper back strength or motion
Movements requiring lower back strength or motion
Movements requiring wrist strength or motion
Movements requiring shoulder strength or motion
Movements requiring knee strength or motion
Movements requiring foot strength or motion

# Thank You

for taking the time to fill out this health history questionnaire. This information is important in the doctor obtaining a clinical picture so as to make an appropriate diagnosis & treatment plan. Please sign below authorizing that the information in this form has been read & filled out completely & accurately to the best of your understanding. Also, understand that the information in this form is considered confidential & for use by your doctor. Any disclosure is outlined in our privacy policies.

Patient's signature (*or guardian's signature*): _____Date: _____

Signature of translator or person assisting with this form: _____Date: _____

Printed name of said person: _____

Doctor's Notes: _____

_____

_____

_____

_____

Doctor's Initials: _____