Advanced Medical Massage
WELLNESS GROUP

Exceptional Treatment Massage
1112 Finnegan Way, Bellingham, WA 98225
360-527-9566 Fax 360-527-8534
www.mmWellness.com

Today's Date: ___/___/___

Motor Vehicle Accident Injury Information

Name: _____

Date of Accident: _____ Time: _____

Place (intersection/city/state): _____

Please describe, to the best of your knowledge, what happened during this accident: _____

_____

_____

Did you go to the emergency room? ___YES ___NO Did you have imaging done? ___YES ___NO

Road conditions at time of accident: _____ Wet _____ Dry _____ Icy

Where were you seated in vehicle? Driver Passenger Back Seat

Were you aware of the approaching collision prior to impact or did it catch you by surprise? _____

How far is the top of the headrest from the top of your head? _____

Were you struck from _____ Behind _____ Front _____ Left side _____ Right side

Were you wearing a seatbelt? _____ Lap belt only? _____ Shoulder & lap belt? _____

Is your car equipped with an airbag? _____ Did it activate? _____

Was the car stopped at the time of impact? _____

If yes, was the driver's foot on the brake? _____ On the clutch? _____

If no, then estimate the speed of the vehicle you were in: _____ mph

Number of people in your vehicle? _____

What type of car were you in? (year/make/model) _____

What type of car impacted with your vehicle? (year/make/model) _____

Was the other vehicle moving at the time of the collision? _____ How fast? _____mph

What bruises or cuts did you get from this accident? _____

Did any of your body parts hit any parts of the car? (i.e., your head on the dash, your shoulder on the door, etc)

_____

_____

What position was your head facing upon impact? _____

_____

Did your car hit anything else after it was hit? _____

Did pain begin _____ suddenly after trauma or _____ gradually after trauma?

Please Turn Over

Are symptoms worse at a certain point of the day? _____

How long have these pain complaints/symptoms been present?

- ☐ less than one week
- ☐ less than six weeks
- ☐ more than six weeks
- ☐ more than three months
- ☐ more than one year

The pain is: ☐ constant ☐ comes & goes and lasts for _____ minutes
_____ hours
_____ days

What activities make your pain complaints/symptoms worse? _____

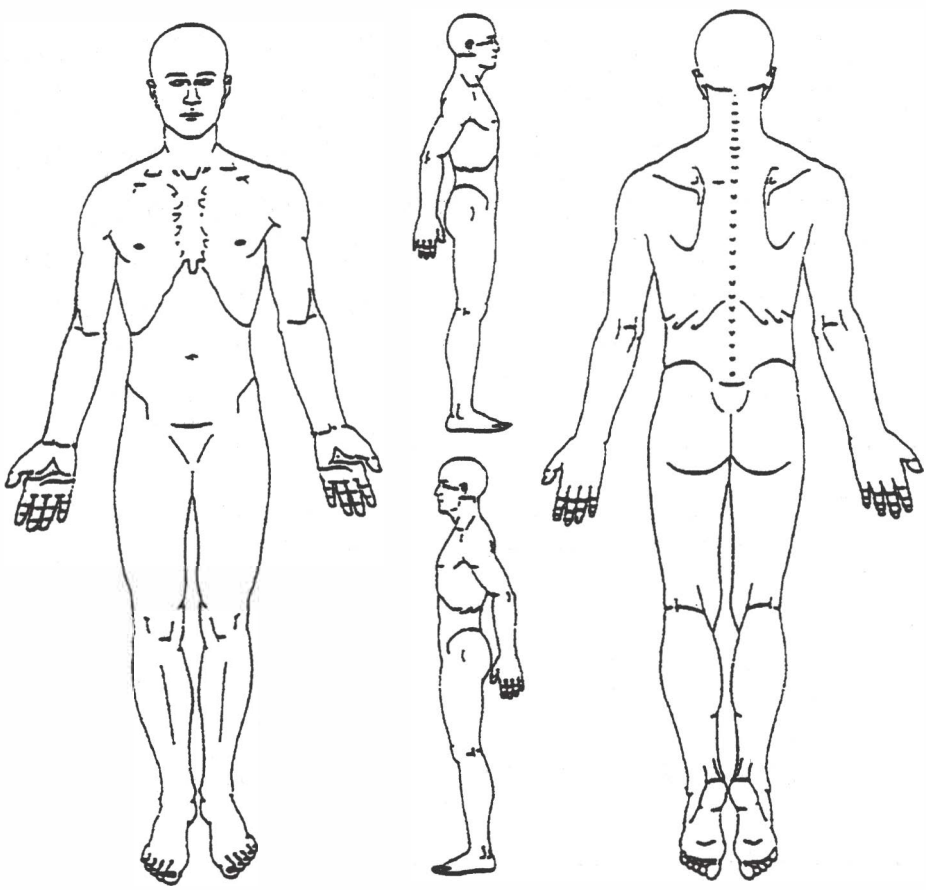
_____

What activities make your pain complaints/symptoms better? _____

_____

On the pictures below, use the indicated marks to show areas where you have experienced:

pain ◯	spasm ≈	weakness W
numbness N	tension =	throbbing T
tingling ⚡	ache A	burning ✳



Client Signature: _____ Date: _____