

Motor Vehicle Accident Patient History

33. Check symptoms apparent since the accident:

- | | | |
|---|--|--|
| <input type="checkbox"/> headache | <input type="checkbox"/> loss of smell | <input type="checkbox"/> numbness in fingers |
| <input type="checkbox"/> neck pain/stiffness | <input type="checkbox"/> loss of taste | <input type="checkbox"/> cold hands |
| <input type="checkbox"/> mid back pain | <input type="checkbox"/> loss of memory | <input type="checkbox"/> cold feet |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> fatigue | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> light sensitive eyes | <input type="checkbox"/> tension | <input type="checkbox"/> constipation |
| <input type="checkbox"/> pain behind eyes | <input type="checkbox"/> breath shortness | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> irritability | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> fainting | <input type="checkbox"/> depression | <input type="checkbox"/> cold sweats |
| <input type="checkbox"/> ringing/buzzing ears | <input type="checkbox"/> sleeping problems | <input type="checkbox"/> anxious |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> numbness in toes | <input type="checkbox"/> other |

34. Occupation: _____ 35. Employer: _____

36. Have you missed time from work? YES/NO

37. If yes, full time off work _____ to _____

38. If yes, part time off work _____ to _____

39. Did you seek medical help immediately after the accident? YES/NO

40. If yes, how did you get there? someone else drove me ambulance drove own car
 police other: _____

41. Were you hospitalized as a result of this accident? YES/NO

42. If yes, where were you hospitalized? _____

PLEASE DIAGRAM BELOW HOW THE ACCIDENT HAPPENED