Oxford Rehabilitation Center

Motor Vehicle Injury Form

Patient Name: _____ Date: _____

Date of accident: _____

Were you the driver of the car? Yes No

If not, were you the ( )front seat or ( )rear seat passenger

Did the Airbags come out? Yes NO

Did you have your seatbelt on? Yes NO

At the time of the accident was a car/truck moving? Yes No

If you were **traveling (car moving)** were you:

( )Traveling through intersection.

( ) Traveling on the highway

( ) Traveling on a 2 way lane

( ) Traveling on one-way road.

( ) In a parking lot

( ) Other: _____

OR was your car was stopped at the time of the accident were you:

( )Stopped in traffic

( )Stopped at a red light

( )Stopped at a stop sign

( )Stopped making a left-hand turn

( )Other: _____

Describe the vehicle that hit you (circle the one): Bus Tractor trailer Flatbed Truck SUV Large car medium size car small car Bike Utility vehicle Other:_____

Where was your vehicle struck on the?

( )Driver-side ( )passenger side ( ) head-on collision ( )rear end collision

Were you: ( )side swiped ( ) T-Boned (broad sided)

Or did your vehicle strike the other vehicle on the

( )Driver-side ( )passenger side ( ) head-on collision ( )rear end collision ( ) street pole ( ) Fence ( )person/animal Curb ( ) concrete wall/divider ( ) other _____

Were you: ( )side swiped ( ) T-Boned (broad sided)

Were you braced for the accident (did you see the other vehicle coming before you were hit)?

Yes No

Did you strike any part of your body (please circle all body parts that you struck) shoulder arms elbows hands head back hip thighs knees legs ankle feet?

Did your body or head strike: ( )Headrest ( )Door ( )dashboard ( )rear-view mirror ( )Console ( )foot-break ( )seat ( )other person ( ) packages ( )other:_____

Were you able to get out of the car/truck and walk without help?

Patient Name: _____ Date: _____

Yes NO

Where you bleeding cuts or have bruises?

Yes NO

Did you loose Consciousness (asleep or knocked out)

Yes NO NOT SURE

Immediately following the accident, what symptoms (pain, tingling, burning, dizziness, nausea, cannot hear, trouble breathing, moving a body part or other) did you experience?

_____

_____**Where you unconscious (asleep) immediately after the accident: Yes NO**

Due to go to the hospital or urgent care? Yes NO

Name of hospital: _____

Date arrived _____ Date discharge _____

When did you go to the hospital? ( ) Time of the accident ( ) Few hours later ( ) Next day ( ) A number of days later _____.

How did you get to the hospital? ( )Ambulance ( ) Police ( ) Family member

If taken by the ambulance, did they place you in ( ) Cervical collar ( )Backboard ( )Brace ( )Splint

At the hospital were ( )X-rays ( ) CAT scan ( ) MRI ( ) blood work ( ) Urine collected ( ) EKG

If x-rays, CAT scan or MRI taken which body parts: ( )Head ( )Neck ( )Shoulders ( )Arm/elbow/forearm/wrist ( ) Spine ( ) Hip ( ) Thigh/knee/leg/ankle/foot

Did they take blood, urine, culture (open wounds) or sputum (from Lungs) from you?

Yes NO

While in the hospital did you have ( )injection ( ) medication ( ) IV (needle in arm with bag of medication)
Arm, elbow, hand or thigh, knee leg, ankle, foot ( )wrapped ( )treated for cuts ( )casted

When you were released from the hospital were you given a prescription for:

( ) Muscle relaxor (parfon forte, cyclobenzaprine, flexerol, carisoprodol, soma, Baclofan, Robaxin, Skelaxin, Diazepam _____
( ) Anti-inflammatory (Motrin, ibuprofen, Naprosyn, Celebrex, aspirin) _____
( ) Pain medication (percocets, oxycotin, Tylenol, Tramadol, Norco, Vicodin) _____
( ) Nerve medication (gabpentine, Lyrica) _____

If you went to any additional <u>hospitals, urgent care, physicians or treatment centers</u> after the accident please repeat the same questions that you answered above.

Name of hospital, Doctor or Therapy Center: _____

Date arrived _____ Date discharge _____

Patient Name: _____ Date: _____

When did you go to the hospital, Doctor or Therapy Center? ( ) Time of the accident ( ) Few hours later ( )Next day ( ) A number of days later _____ days.

How did you get to the hospital? ( )Ambulance ( ) Police ( ) Family member ( ) other_____

If taken by the ambulance, did they place you in ( ) Cervical collar ( ) Backboard ( ) Brace ( ) Splint

At the hospital were ( )X-rays taken ( ) CAT scan ( ) MRI ( ) blood work ( ) Urine collected ( ) EKG

If x-rays, CAT scan or MRI taken which body parts: ( )Head ( ) Neck ( ) Shoulders ( ) Arm/elbow/forearm/wrist ( ) Spine ( ) Chest/ribs ( ) Hip ( ) Thigh/knee/leg/ankle/foot

While in the hospital did you have ( ) injection ( ) medication ( ) IV (needle in arm with bag of medication)
Arm, elbow, hand or thigh, knee leg, ankle, foot ( )wrapped ( )treated for cuts ( )casted

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( ) Nerve medication (gabpentine, Lyrica) _____

Did you have any physical therapy/chiropractic: ( ) hot packs/cold packs ( ) Exercise ( ) Pool therapy ( ) electric muscle stimulation ( ) ultrasound ( ) paraffin wax ( )massage ( ) Manipulation

Check symptoms/pain/numbness/weakness that you experienced **after this accident**:

( ) Headaches
( ) Neck pain
( ) Shoulder pain ( ) R ( ) L
( ) Arm/Elbow pain ( ) R ( ) L
( ) Hand/wrist pain ( ) R ( ) L
( ) Upper and middle back
( ) Chest pain
( ) Low back pain
( ) Abdomen/stomach
( ) Hip pain ( ) R ( ) L
( ) Knee pain ( ) R ( ) L
( ) Foot/ankle pain ( ) R ( ) L

Burning, tingling, numbness, weakness, PAIN
( ) Radiating to shoulder
( ) Radiating to your hand/fingers
( ) Radiating to hip or buttock
( ) Radiating to thigh
( ) Radiating to leg or feet/toes
( ) Radiating around chest/ribs

( ) Mood changes
( ) Irritability
( ) Nervousness
( ) Increase Menstrual pain
( ) Eyes sensitive to light
( ) Fainting/ Dizziness
( ) Anger issues
( ) Dry Mouth
( ) Loss of sensation to your face
( ) Loss of Smell
( ) Feeling Depressed
( ) Cold feet/hands
( ) Coughing up blood
( ) Blood in Urine
( ) Change in frequent urination
( ) Blurred vision
( ) Loss of balance
( ) Trouble climbing steps
( ) Trouble going down steps

( ) Double vision
( ) Confusion
( ) Difficulty concentrating
( ) Difficulty finding words
( ) Ringing in the ear
( ) Loss of taste-food taste different
( ) Loss of memory
( ) Short term (lost keys)
( ) Long-term (a loved one's name)
( ) Difficulty finding words
( ) Difficulty counting money
( ) Difficulty adding numbers
( ) Nausea
( ) Vomiting
( ) Difficult of falling asleep
( ) awaking at night
( ) Sexual inability
( ) Difficulty holding onto a cup
( ) Tripping over your feet