Pre-MVA Visit Questionnaire

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Please print and complete this Pre-MVA Visit Questionnaire and bring with you to your appointment.

Patient First Name:		Patie	Patient Last Name:	
Date of Accident:				
You were:	river	ger 🗆 a pedes	strian	
\Box other	– please specify:			
If you were a passenger,	, you were sitting in	ı:		
\Box front	□ back-left □ b	ack-right		
Did you have a seatbelt	on? ☐ Yes	□ No	\square Not applicable (pedestrian/other)	
Did the airbag deploy?	☐ Yes	□ No	\square Not applicable (pedestrian/other)	
Briefly describe how the	accident happened	d:		
Did an ambulance take y	you to a hospital?	☐ Yes	□ No	
How did you feel after the	he impact?			
Have you missed work?	☐ Yes	□ No		

Please identify your areas of discomfort: CHECK ALL THAT APPLY
□ Head
□ Neck
☐ Upper back
□ Lower back
☐ Chest
☐ Abdomen
☐ Right arm
□ Left arm
☐ Right leg
☐ Left leg
What are your symptoms today?
Have you ever had anything like this before? ☐ Yes ☐ No
If yes, give details:
What makes your symptoms worse?
,
What makes your symptoms better?
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What is troubling you most?
Have you been in previous motor vehicle accidents that resulted in injuries? ☐ Yes ☐ No
If yes, what was the date:
If previous motor vehicle accidents, have you fully recovered from the previous MVA?
☐ Yes ☐ No ☐ Not applicable