ActiveLife Chiropractic MVA Form
Dr. Jocelyn Kirnak, D.C.
5201 SW Westgate Dr. #119 Date:_____
Portland, OR 97221 (503)335-0449

PATIENT INFORMATION
__ Dr. __Mr. __ Mrs. __Ms. __ Miss Marital Status: __M __S __W __D

Last Name_____ First Name _____
Nick Name _____
Address
_____City_____
State_____ Zip Code_____
Cell Phone: _____ Home Phone:_____
Email: _____D.O.B._____
Sex: ____M _____F Occupation: _____
Employer:_____WorkPhone:_____
Emergency Contact: _____Phone: _____
RESPONSIBLE PARTY
Name of driver of car you were in:
_____
Relationship to Patient: _____ Phone: _____
Address_____City_____
___ State_____Zip Code_____
AUTO INSURANCE INFORMATION
Name of Insurance: _____ Policy# _____
Claim #: _____ _____Yr./Make/Model of vehicle_____
If you have not done so, please complete an application for Personal Injury Benefits with Car Insurance Co.
Personal Health Insurance: _____Policy #: _____
CRASH/INJURY HISTORY

Date of incident: _____ Time of day: _____ City where it occurred: _____
Were you: _____ Driver _____ passenger ____ back seat _____ pedestrian/cyclist
Number of people in vehicle: _____
Were you wearing a seat belt? ___ yes _____no
Were you wearing a lap belt? ___ yes ____ no
What direction were you headed? ___north ____south ____east ____west
On (name of street and city):
_____
What direction was the other vehicle headed? ___north ___south ____east ___west
On (name of street and city):
_____
Were you struck from ___Behind ___Front ___Left Side ____Right Side
Other combination, please describe briefly:
_____
_____
_____
At the time of impact, your vehicle was: __slowing down __Gaining speed__ stopped __ unknown __ steady speed

ActiveLife Chiropractic/5201 SW Westgate Dr.#119/Ptld., OR 97221
Name_____Date_____

What was the position of your head during the crash? ____ Straight ahead
___Turned right ___Turned left ___ Other
How many vehicles were involved in the crash? _____
During or after the crash, your vehicle: ___kept on going straight, not hitting anything ____spun around
____Was hit by anther object
Did any part of your body strike/hit anything inside the vehicle (steering wheel, dashboard, ect)? ___ Y ___N
Did any items become displaced in the vehicle (mirror, purse, packages)? ___Y ___N
If your vehicle was equipped with air bags, did they activate? ___Y ___N
Make /model of the other vehicle(s): _____
Were the police notified? _____ Y ____N Please provide this office with a copy of the police report!
In your own words, please describe the crash:_____
_____
_____
_____
_____
Did you have any physical complaints before the crash? ___Y ___N
If yes, Please describe in detail:
_____
_____
_____
_____
Please describe how you felt:
DURING THE CRASH:
_____
_____
IMMEDIATELY AFTER THE CRASH:
_____
_____
LATER THAT DAY:
_____
_____
THE NEXT DAY:
_____
_____
Did you lose consciousness during the crash? ___Y ___N ___Maybe ___ Unknown
IF yes, for how long? _____
Have you been treated by another doctor since this accident? ___Y ___N
If yes, please list the doctor's name, address and phone number:
_____
_____
_____
_____
What type of treatment did you receive?
_____
_____
_____
_____

ActiveLife Chiropractic/5201 SW Westgate Dr. #119/Ptld., OR 97221
Name_____Date_____
Did this accident occur while you were performing your regular job duties? ____ Y ____N
What is your number one problem or the one area of greatest pain since the crash? _____
_____
_____
Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain.
0 1 2 3 4 5 6 7 8 9 10
Since this injury occurred, is your pain: ___Improving ___ Getting Worse ____Staying the same
How often do you experience the pain? ___1-2 Hrs per day ___ 1/2 the day ___Most of the day ___Constantly
How does the pain affect your daily activities?
____It does not affect my daily activities ____I have had to change how I do many things ___ I have had to stop doing some of my daily activities _____I am unable to perform any regular daily activities
What increases your pain?_____
_____
What decreases your pain?
_____
_____
Have you ever experienced this problem before? __Y __N When?
_____
Do you have a previous illness/disease that affects your present condition? __ Y ___N If yes, please describe:
_____
_____
Indicate if your body hit something or was hit by any of the following: (Please draw lines from the body regions on the left side and match to the right side.)

BODY REGION: YOU HAD CONTACT WITH:	OBJECT
HEAD	
WINDSHEILD	
FACE	
SIDE SHOULDER	
SHOULDER	SIDE
DOOR	
ARM/HAND	
DASHBOURD	
FRONT CHEST WALL	GLOVE COMPARTMENT
SIDE CHEST WALL	SEATBELT
HIP/ABDEMON	FRAME OF
CAR NEAR WINDOWS	
KNEE	
ROOF OF CAR	
LEG	
ANOTHER OCCUPANT	
FOOT	
ROOF	
Steering Wheel/column	

ActiveLife Chiropractic/5201 SW Westgate Dr. #119/Portland, OR 97221
Name_____Date_____

Check if any of the following vehicle parts broke, bent or were damaged in your car: ___Windshield ___side or rear window ___ seat frame ___knee bolster ___steering wheel ___brake pedal ___dash ___mirror ___other
YES/NO: Did any of the front or side structures, such as the side door, dash, or floorboard of your car dent inward during the crash?
Y/N Did the side door touch your body during the crash?
Y/N Was the door(s) of your vehicle damaged to a point were you couldn't open the door?
Y/N Did your body slide under the seatbelt?
Y/N Were you holding onto the steering wheel (driving only) at the time of impact?
If yes, indicate where each hand was positioned (Use time clock face as your reference point)
Left Hand: _____not on wheel _____Yes, hand at ____o'clock _____ hand elsewhere
Right Hand: _____not on wheel _____Yes, hand at ___ O'clock _____hand elsewhere

REAR-END COLLISIONS ONLY:
Describe your vehicles head restraint system:
_____Movable/adjustable head restraint ____ fixed, non-movable head restraint
_____No headrests in vehicle _____Bench seat in vehicle without head restraint
PLEASE INDICATE HOW YOU'RE HEAD RESTRAINT WAS POSITTIONED AT THE TIME OF CRASH (if present):
_____At the top of the back of your head _____Midway height of the back of your head
_____Lower height of the back of your head ____ Level of your back _____ Level of your shoulder blades
ESTIMATED DISTANCE BETWEEN BACK OF HEAD AND FRONT OF HEADREST:
_____

Y/N Did your body have any bruising (areas that were visibly black and blue) after the crash?

If yes, indicate where_____
_____
Y/N You were unaware of the impending collision. You did NOT see or hear brakes prior to the impact.

Y/N you were aware of the impending crash and relaxed before the collisions
Y/N You were aware of the impending crash and braced yourself
Y/N Your body/torso and head were facing straight ahead
Y/N You had your head and /or torso turned at the same time of the collision: ___turned to the left ___Turned to the right

ActiveLife Chiropractic/5201 SW Westgate Dr #119/Ptld., OR 97221
Name_____ Date_____
Describe how far you were twisted and why:
_____
Y/N You were leaning forward at the time of the crash resulting in a gap between your body and the seatback
Y/N Your torso and body was positioned normally against the seatback with no gap due to leaning/twisting

Emergency Room and Disability Dates:
Y/N Did you go to the emergency room afterward? If yes, date and time:_____
Y/N Did you go to the emergency room in the ambulance?
Y/N Did you or another person drive you to the emergency room? Name of driver:_____
List any other complaints currently bothering you and rate your pain level for each.
a. _____ 0 1 2 3 4 5 6 7 8 9 10
b. _____ 0 1 2 3 4 5 6 7 8 9 10
c. _____ 0 1 2 3 4 5 6 7 8 9 10
d. _____ 0 1 2 3 4 5 6 7 8 9 10
Have you ever been involved in another accident before? ___Y ____N
If yes, when?
_____
_____
Describe that accident:_____
_____

Were you injured ? ___Y ___N Explain:
_____
_____
_____
_____
List all over-the-counter and prescribed medications you are currently taking:
_____
_____
_____
List all surgeries you have had (with date):
_____
_____
_____
Describe all activity restrictions as a result of this most current accident:
_____
_____
_____
_____
_____
Y/N Were you hospitalized after being seen in the Emergency Room?
If yes, how many days:
_____

ActiveLife Chiropractic/5201 SW Westgate Dr #119/Ptld OR 97221
Name_____Date_____

Did the emergency room doctor take X-Rays? Check what regions x-rays were taken:
___Skull/Face ____Ribs/ Chest
___Neck or middle back ____Collar Bone
____Low back or hip/pelvis _____Shoulder, Arm or hand
____Leg/Foot ____Other
Did the hospital or clinic take MRI or CT of your body? If yes, indicate were taken:
____ Skull ____neck ___low back or hip/pelvis ____other
Did you have any broken bones/ fractures? If yes, where:
_____
Did you have a cast put on for any sprain or fracture? If yes, type/location:
_____
Did you have nay dislocations? If yes, where:
_____
Did you have any lacerations? If yes,
where:_____
_____
Did you have any skin abrasions? If yes, where:
_____
Did you require stitching for any cuts? If yes,
where:_____
Did the Emergency room doctor give you any pain medications?
Did the Emergency room doctor give you any muscle relaxants?
Were you told you had a herniated disk or bulging disc in your neck or back?
If yes, where:
_____
_____
Were you given a neck collar or back brace to wear?
Did you require any surgery after the accident?
How soon did you first notice any pain or soreness after the crash? ___Less than 24 hrs ____ 1-7 days _____longer
If you did not see a doctor for the first time until after 2 weeks from the injury date, indicate why: (check all that apply only if you had a delay in seeing a doctor)
___ No pain was noticed

___ No appointment schedule available
___ Thought pain would go away
___ No transportation
___ Work/home scheduling conflicts
___ Other:
_____
_____
Have you lost days off work? If yes, you were off work ___partially
___completely
Dates: _____ to _____

ActiveLife Chiropractic/5201 SW Westgate Dr. #119/Ptld., OR 97221
Name:_____
Date:_____

It is very important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom that applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom does not apply to you.

SYMPTOM LIST	BEGAN IN LESS THAN 24 HRS AFTER INJURY	YOU HAVE SYMPTOMS CURRENTLY	HAD SYMPOTOMS WITHIN 1 YR BEFORE INJURY
Headache/migraine			
Dizziness			
Tinnitus (ear ringing)			
Blurry vision			
Loss of memory			
Poor concentration			
Irritability			
Balance problems			
Loss of coordination			
Sensitivity to sound			
Sensitivity to light			
Fatigue			
Anxiety			
Pain/difficulty swallowing			
Jaw pain / soreness			
Neck pain/ soreness/aching			
Neck stiffness			
Shoulder pain/stiffness			
Arm pain/tingling/numbness			
Wrist/hand/finger pain/numbness			
Weakness in arms/legs			
Upper/ middle back pain/soreness			
Rib cage pain			
Low back pain/soreness/aching			
Hip pain			
Leg pain			
Leg numbness/tingling			
Pain shoots down back of leg			
Knee pain/soreness			
Ankle/foot pain /soreness			

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered to the best of my ability. I understand that providing incorrect information can be dangerous to my health and wellbeing. I authorize this office to release my information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for these services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that there is a fee if I miss or cancel and appointment without a full 24 hours notice, non-payable by insurance.

Patients Signature: _____

Date: _____

(Signature of parent/ guardian if the patient is a minor)

PATIENT NAME: _____ DATE: _____

ActiveLife Chiropractic 5201 SW Westgate Dr. # 119

Portland, OR 97221