Date:

Initial MVA questionnaire

Name:
Date of Birth: Height: Weight: BP/HR

ICBC claim number:
Date/Time of accident:
Intersection of accident: City of accident:
Make/Model/Year of vehicle you were in:
Were you driver, passenger, pedestrian?
Were you wearing your seat belt? Y/N Were the air bags deployed in your car? Y/N

How did the accident happen?

Did you lose consciousness after the accident?

Were you confused after the accident? How long did it last?

Did your car sustain a lot of damage?

Did you hit your head on anything at the time of the accident?

What can you say about the impact of the accident?

If rear ended, was your car pushed ahead? How far?

Did you go to ER or clinic after the accident? Date?

What type of therapy have you had since the car accident?

___ Physio ___Massage ___Naturopath
___Chiro ___Acupuncture ___Active rehab

What medications have you had since the car accident?

Which of the following symptoms have you had since the car accident?

- Neck pain
- Back pain
- Shoulder pain – R L both sides
- Arm pain
- Elbow pain
- Wrist pain
- Hand pain
- Foot pain
- Knee pain - R L both
- Hip pain R L both
- Leg pain R L both
- Jaw pain
- Ringing in the ears
- Headaches
- Dizziness
- Forgetfulness
- Confusion
- Unable to sleep
- Back pain -> legs
- Numbness of the legs
- Neck pain -> arms
- Numbness of the arms
- Depression
- Anxiety

Have you ever had symptoms or received treatment for the areas injured in this accident?
If yes, please describe.

Please list any other medical conditions you have

<u>School</u>
Are you currently in school?
Before accident were you attending full or part time?
What program and what school?
When will you graduate?

How has the car accident injuries interfered with school?
What can you NOT do since the accident?
Since the accident are you attending full or part time?
Will your graduation be affected?

<u>Work</u>
Were you working before the car accident?
Full or part time? Self-employed?
Where do you work?
What is your occupation?

Have you worked after the accident?
Full or part time? Self-employed?
Same occupation as above?

Please describe in detail your typical day at work? Does it involve any heavy labor?

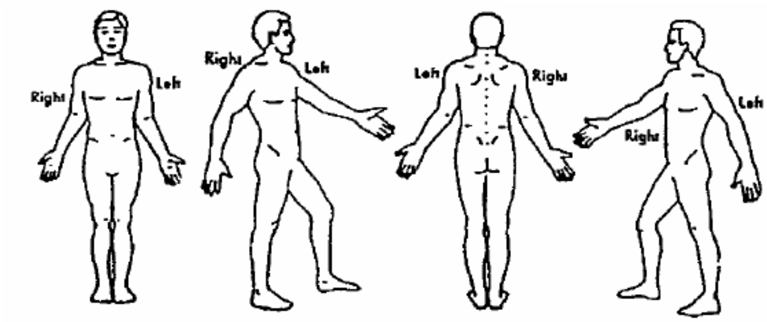
Have you missed any time from work? How long?

Did you have to modify your working hours or duties?

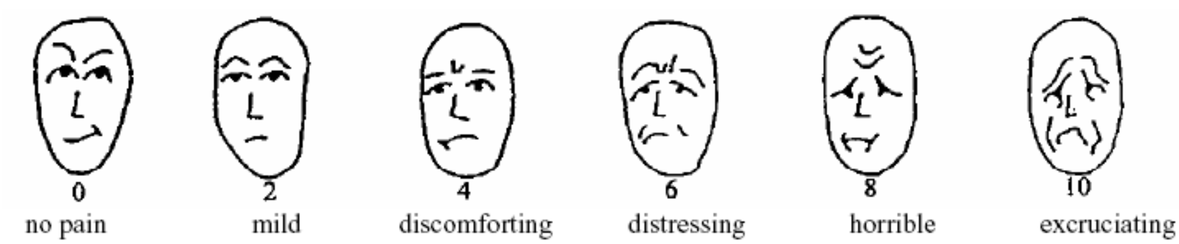
Are there any NON-WORK activities that you cannot do since the accident?

Pain Assessment Tool

1. Location of pain:



2. Severity of Pain:



QUESTIONS	COMMENTS
What is the present level of pain? **(if no pain is present complete sections 6 and 7)**	
What is the rate when the pain is at its least?	
What makes the pain better?	
What is the rate when the pain is at its worst?	
What makes the pain worse?	
Is the pain continuous or intermittent?	
When did the pain start?	
What do you think is the cause of this pain?	
What level of pain are you satisfied with? (if 0 is unattainable)	

3. Quality: Indicate the words that describe the pain

□ aching	□ throbbing	□ shooting	□ stabbing	□ gnawing	□ sharp
□ burning	□ tender	□ exhausting	□ tiring	□ penetrating	□ numb
□ nagging	□ hammering	□ pins & needles	□ unbearable	□ tingling	□ stretching
□ pulling	other:				

4. Effects of pain on <u>activities of daily living</u>

Activities of daily living	Yes	No	Comments
sleep and rest			
social activities			
appetite			
physical activity and mobility			
emotions			
sexuality/intimacy			

5. Effects of pain on <u>quality of life</u>

What would you like to do now that you can't do because of the pain **or** What activity would improve your quality of life?
____
____

6. Symptoms: What other symptoms are being experienced?

□ constipation	□ nausea	□ vomiting	□ fatigue	□ insomnia	□ depression	□ drowsy
□ sore mouth	□ weakness	□ short of breath	other:			

7. Behaviours: What behaviours are present that may be a result of pain or treatment?

□ calling out	□ restlessness	□ disorientation	□ not eating	□ pacing
□ not sleeping	□ withdrawn	□ groaning/moaning	□ rocking	□ new immobility
□ tense	□ distressed	□ distracted	□ crying	□ inexpressive
□ fists clenched	□ striking out	□ knees pulled up	□ frowning	□ facial grimacing
□ resistant to movement	□ pulling or pushing away	□ sad	□ frighten	other

8. Past pain management

Has a significant degree of pain been experienced in the past? How was that managed?
____
____

Past use of pharmacological and non-pharmacological pain management?
____
____

9. Support system:____

10. Other concerns related to pain____

Date Care Plan updated: ______________________

Signature: ____________________________________ **Assessment Date:** ________________________