



EMBODY HEALING ARTS
Medical & Wellness Massage

Clinically Effective Bodywork Grounded in Experienced, Holistic Understanding
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Motor Vehicle Accident Injury Information

Name: _____

Date of Accident: _____ Time: _____

(intersection/City/State): _____

Please describe, to the best of your knowledge, what happened during this accident: _____

Road Conditions at Time of Accident: ☐ Wet ☐ Dry ☐ Icy

Where were you seated in the vehicle? _____

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? _____

Were you struck from ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Were you wearing a seatbelt? ☐ ☐ Lap belt only ☐ Lap & Shoulder belt

Is your car equipped with an air bag? ☐ Did it activate? ☐

Was the car stopped at the time of impact? _____

If yes, was the driver's foot on the brake? _____ On the clutch? _____

If no, then estimate the speed of the vehicle you were in: _____ mph

Number of people in your vehicle? _____

What type of car were you in?

(year/make/model) _____

What type of care impacted your vehicle?

(year/make/model) _____

Was the other vehicle moving at the time of collision? _____ How fast? _____ mph

What bruises or cuts did you get from this accident? _____

Did any of your body parts hit any parts of the car? _____

What position was your head facing upon impact? _____

Did pain begin: ___ Suddenly after trauma ___ Gradually after trauma

Are symptoms worse at a certain point of the day? _____

How long have these complaints/symptoms been present?

___ Less than one week ___ Less than six weeks ___ More than six weeks

The pain is: ___ Constant ___ Comes and goes and lasts for: _____ minutes/hours/days

What activities make your pain/symptoms worse? _____

What activities make your pain/symptoms better? _____

On the pictures below, use the indicated marks to show areas where you have experienced:

O Pain

N Numbness

Z Tingling

S Spasm

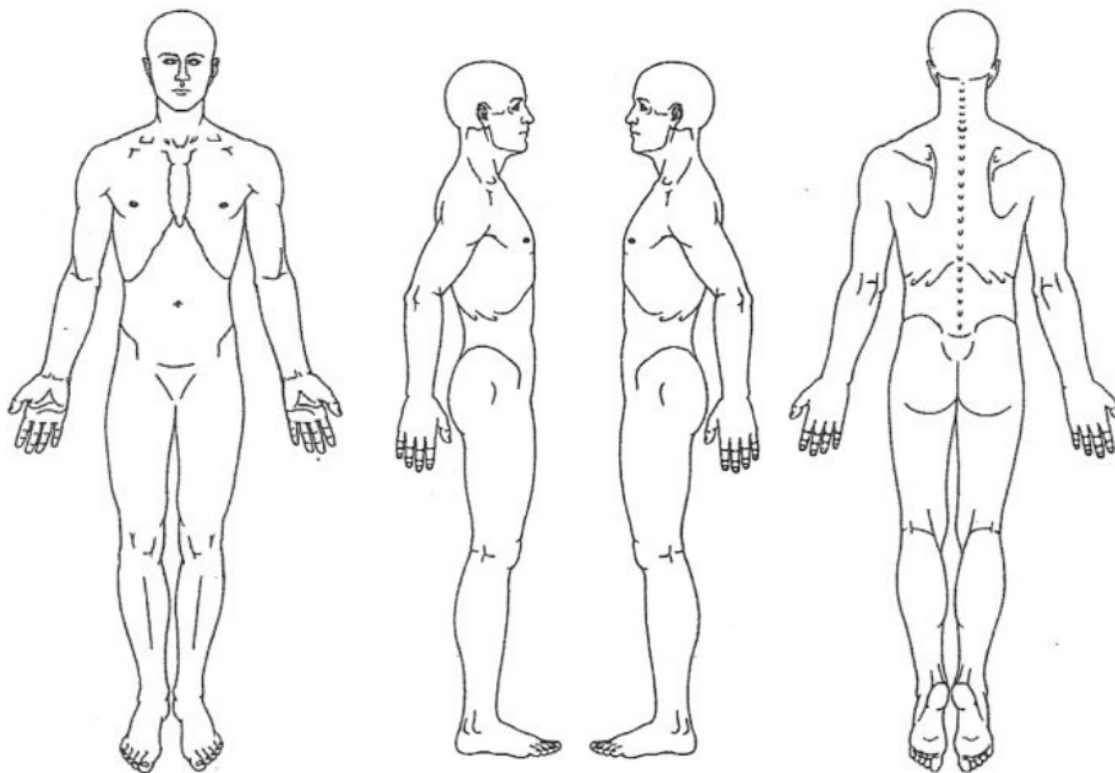
// Tension

A Ache

W Weakness

T Throbbing

X Burning



Client Signature: _____ Date: _____