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MOTOR VEHICLE ACCIDENT DESCRIPTION REPORT

NAME _____ TODAY'S DATE _____

AGE _____ DATE OF BIRTH ____/____/____ OCCUPATION _____

DATE OF MVA ____/____/____ TIME OF MVA _____ AM/PM

WEATHER CONDITIONS _____

LOCATION OF MVA _____

TYPE OF VEHICLE PATIENT IN _____

OTHER VEHICLE _____

WHERE SEATED IN VEHICLE _____

RESTRAINTS WORN YES / NO

DESCRIPTION OF MVA _____

SPEED OF YOUR CAR _____ SPEED OF OTHER CAR _____

TICKET GIVEN YES / NO WHO RECEIVED TICKET? _____ WHY? _____

HEAD POSITION _____ HANDS POSITION _____

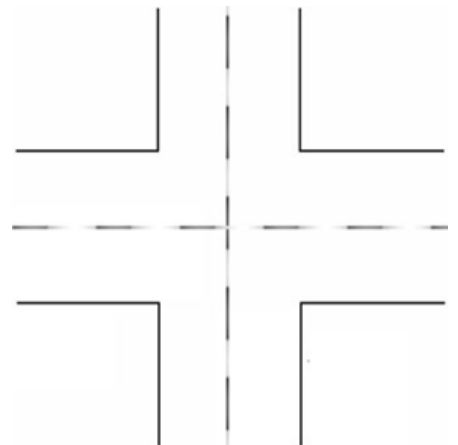
EMERGENCY TREATMENT YES / NO WHERE _____ IF NOT WHY? _____

PRESCRIPTIONS GIVEN? YES / NO WHAT _____

X-RAYS TAKEN YES / NO WHERE? _____ OTHER TREATMENT – WHO & WHERE _____

IMMEDIATE SYMPTOMS _____

PRESENT SYMPTOMS _____



TIME MISSED FROM WORK? _____ DAMAGE TO YOUR VEHICLE _____

COGNITIVE PROBLEMS _____

EMOTIONAL PROBLEMS _____

PRIOR HISTORY OF SIMILAR INJURY OR SYMPTOMS _____

PRE-EXISTING MEDICAL CONDITIONS _____

PATIENT SIGNATURE _____

DATE ___/___/___