MVA Symptom Checklist

History (Patient/Claimant to Complete)

Patient Name: _____ Date: _____

1. Symptom Checklist

For each symptom, check **YES (if present)** *or* **NO (if not present)**, *and rate severity on a scale of* **0** *to* **10** *where indicated* **0** *is* **"No Pain"** *and* **10** *is* **"Pain as Bad as it Could Be."**

Neck or shoulder pain ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Upper or Mid-back pain ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Low back pain ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Headache ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Arm(s) ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Hand(s) ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Face or Jaw ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Leg(s) ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Foot/Feet ☐ YES ☐ NO

No Pain — Pain as Bad as Could Be

0	1	2	3	4	5	6	7	8	9	10

Pain in Abdomen or Chest ☐ YES ☐ NO

No Pain — Pain as Bad as Could Be

0	1	2	3	4	5	6	7	8	9	10

Feeling of numbness, tingling in arms or hands ☐ YES ☐ NO

Feeling of numbness, tingling in legs or feet ☐ YES ☐ NO

Dizziness or unsteadiness ☐ YES ☐ NO

Vision problems ☐ YES ☐ NO

Hearing problems ☐ YES ☐ NO

Anxiety or worry ☐ YES ☐ NO

Nausea or vomiting ☐ YES ☐ NO

Difficulty swallowing ☐ YES ☐ NO

Problems concentrating ☐ YES ☐ NO

2. Loss of consciousness ☐ YES ☐ NO

3. Have the injuries prevent you from carrying out any of the following:

Explain

☐ Daily home activities _____

☐ Employment _____

☐ Schooling _____

☐ Sports or recreation _____

☐ Other _____

4. Do you think your injury will:

☐ get better soon

☐ get better slowly

☐ never get better

☐ don't know