evolve

THERAPEUTIC MASSAGE INC.

MOTOR VEHICLE ACCIDENT REPORT FOR: ____________________________________ CLAIM #: __________________

ADJUSTER: __________________________ MVA Date: __________________ LAWYER: _________________________

Please circle:

Were you the driver? / passenger? / pedestrian?

Were you wearing a seatbelt? Yes / No

Did you anticipate the impact? Yes / No

Did your car hit any other object or vehicle? Yes / No

Was your foot on the brake? Yes / No

Did you hit the steering wheel? Yes / No Head Rest? Yes / No Airbag? Yes / No

Door? Yes / No Other __________________

What direction were you looking? Forward Right Left

Where were your arms (position)? Steering wheel/ arm rest/ other ____

Were you hit from the **Back** (rear-ended), **Side** (left or right), **Front**? ____

What speed was your car going? _______________________ km/h Other car: _______________________ km/h

Make, model and year of your car: _______________________________ Other car: ____________________________

Value of damage to your car: $ __________________________________

Did you go to the hospital? Yes / No

Have you seen your doctor? Yes / No Dr: ____

List any prescribed medications from MVA? ____

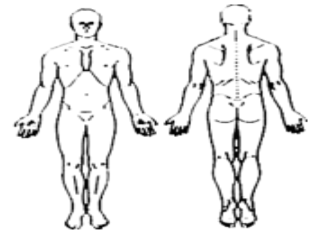
Briefly describe what happened: ____

____

____

____

Symptoms: Please check any that apply to you in relation to this accident



Indicate areas of pain

- ☐ Tingling/numbness
- ☐ Stiffness
- ☐ Fatigue/Weakness
- ☐ Jaw Pain
- ☐ Ringing in ears
- ☐ Headaches
- ☐ Forgetfulness
- ☐ Lack of concentration
- ☐ Dizziness

When did your symptoms first appear? ______________________________________

Describe where you feel pain: ____

Did they start gradually or suddenly? ____

What aggravates the symptoms? ____

What is your activity level now compared to before the accident? ____

Is there anything you have difficulty doing now? ____

Has the accident affected your driving? Yes / No Your Sleep: Yes / No

Work schedule (hrs/wk): Prior to MVA: _______________________________ Currently: ________________________

Medications not related to accident? (List)____

____

Have you been involved in previous car accidents? Yes / No When? _____________________________________

Have you had any previous injuries? ____

SIGNATURE: ____ DATE: ________________________