MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Please take a moment to complete this MVA questionnaire to better help us provide the best possible treatment.

Were you working during the time of your accident? ☐ Yes ☐ No

Full Name: _____ DOB:_____

Care Card Number: _____ Do you have a Laywer? ☐ Yes ☐ No

ICBC Claim Number: _____ Accident Date & Time: _____

Adjusters Name: _____ Adjusters' Ph or email: _____

Please describe the accident in your own words:

_____

_____

_____

What was your position in the car?

Driver: Were your hands on the steering wheel? ☐ Left ☐ Right ☐ Both

Passenger: Were you sitting in ☐ Front ☐ Right rear ☐ Left rear

Did your vehicle strike another vehicle? Yes / No Was your vehicle struck by another vehicle? Yes / No

Angles of impact….First Collision: ☐ Front ☐ Back ☐ Left ☐ Right

If Second Collision: ☐ Front ☐ Back ☐ Left ☐ Right

Were you wearing a seatbelt? ☐ Yes ☐ No

Did you brace for impact? ☐ Yes ☐ No ☐ I braced with my hands ☐ I braced with my feet

Which way were you facing at the time of impact? ☐ Straight ahead ☐ Left ☐ Right

Did you body strike anything in the vehicle at the time of impact? ☐ Yes ☐ No

If yes, please specific what body part struck what: ie: head, chest, chin, right/left knee etc.

☐ Steering wheel _____ ☐ Dashboard _____

☐ Windshield _____ ☐ Roof _____

☐ Left Side Door_____ ☐ Right Side Door _____

☐ Left Side Window _____ ☐ Right Side Window _____

☐ Other _____

Did the seat back bend / break ☐ Yes ☐ No

Immediately following the accident, how did you feel?

☐ dizzy/dazed ☐ disorientated ☐ nervous ☐ nauseous ☐ upset ☐ weak

other: _____

Were you knocked unconscious? ☐ Yes ☐ No

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Did you go to the hospital? ☐ Yes ☐ No Were you admitted? ☐ Yes ☐ No If yes, how long? _____

If you went to the hospital, when? ☐ At time of accident Next day

How did you get to the hospital? ☐ Ambulance ☐ Police Car ☐ Private Transportation

Name of hospital: _____

Attended by Doctor: _____

Was treatment given? ☐ None ☐ Placed in cervical collar ☐ X-Rayed

☐ stitches ☐ bandaged ☐ pain medication ☐ given instructions regarding concussions

☐ given instructions regarding sprains and strains ☐ Physical therapy

☐ instructed to call an orthopaedic surgeon ☐ instructed to call a private physician

☐ referred to this office for treatment ☐ other: _____

Have you seen any doctor as a result of this accident? ☐ Yes ☐ No

Doctor's Name: _____ Phone Number: _____

Chief Complaints or Symptoms:

Neck Pain (check all that apply) ☐ no neck pain

☐ left shoulder ☐ left arm ☐ left forearm ☐ left hand

☐ right shoulder ☐ right arm ☐ right forearm ☐ right hand

☐ Headache ☐ Migraine Headache ☐ Upper Back Pain

Ringing in ears:	☐ Yes	☐ No;	☐ Left	☐ Right	☐ Both Ears
Blurry Vision:	☐ Yes	☐ No;	☐ Left	☐ Right	☐ Both Eyes
Jaw Pain:	☐ Yes	☐ No;	☐ Left	☐ Right	☐ Both Sides
Wrist Pain:	☐ Yes	☐ No;	☐ Left	☐ Right	☐ Both Wrists

Are you experiencing any of the following:

☐ dizziness ☐ nervousness ☐ fatigue ☐ anxiety ☐ depression ☐ irritability

☐ fear of driving in a car ☐ a loss of concentration ☐ jaw clenching ☐ teeth grinding

☐ nightmares ☐ difficulty with sleeping at night

Low Back Pain (check all that apply) ☐ no low back pain ☐ buttocks

☐ left buttock ☐ left thigh ☐ left knee ☐ left foot

☐ right buttock ☐ right thigh ☐ right knee ☐ right foot

Hip Pain:	☐ Yes	☐ No;	☐ Left	☐ Right	☐ Both Hips
Knee Pain:	☐ Yes	☐ No;	☐ Left	☐ Right	☐ Both Knees
Foot/Ankle Pain	☐ Yes	☐ No;	☐ Left	☐ Right	☐ Both Feet/Ankles

Are you experiencing any NUMBNESS in any of the following areas:

☐ left hand ☐ left upper arm ☐ right hand ☐ right upper arm

☐ left foot ☐ left leg ☐ right foot ☐ right leg

Have you lost any time from work due to your injuries? ☐ Yes ☐ No

If yes, please give dates: _____

Type of employment: _____

Any other complaints or symptoms:_____

Patient Signature: _____ Date: _____