Eglinton Health Care Centre

Motor Vehicle Accident (MVA) Form

Last Name:	File #:	Date:
First Name:	DOB:	Claims Rep Name:
Auto Insurance Co:	Policy #	Claim #
Personal Insurance Co:	Policy #	

General Information

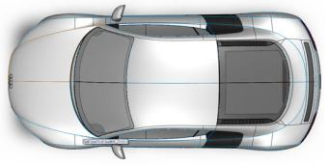
Date of Accident:						
Location	☐ **Driver** ☐ **Passenger**	Location	☐ Front	☐ Middle	☐ Rear	
		Position	☐ Left	☐ Middle	☐ Right	

Work from Left to Right and Circle One

Patients Vehicle	**Type :**	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / compact / Mid Size / Full Size
	Action :	Stopped / Slowing / Acceleration / Cruising
	Speed : KmPH	
	Time of Accident:	Day Light / Dawn / Dusk / Dark
	Road Condition :	Dry / Damp / Wet / Snow / Ice
	Visibility :	Good / Fair / Poor

Enter impact Information

Impact Information: Vehicle or Object (I)

(Select one) ☐ **Vehicle** ☐ **Object**	**Name Object :**	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Damage to Vehicle:	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location (Please Circle)		

Impact Information: Vehicle or Object (II)

(Select one) ☐ **Vehicle** ☐ **Object**	**Name Object :**	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Damage to Vehicle:	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

During Impact Information:

Seat Belt?	☐ Yes	☐ No	Brakes Applied ?	☐ Yes	☐ No

Air Bag Deployed?	☐ Yes	☐ No	Seat Broken ?	☐ Yes	☐ No
Seat Back position Changed?	☐ Yes	☐ No			
Head Rest : (Circle one)	Low / Mid / High / None				
Prepare for Accident: (Circle One)	Un-expected / Expected / Expected and Braced				
Body Position : (Circle one)	Straight / Rotated Left / Rotated Right / Unsure / Other:				
Body Thrown?	☐ Yes / ☐ No				
Direction of Throw :(Circle One)	Backwards / Forward / Outside / Unsure / Other:				
Head Position :	Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:				
Head Motion :	Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other:				

Body Impact (Indicate any parts of your body that were struck during the impact)

☐ Head	☐ Upper Back	☐ Right hand	☐ Lower Back
☐ Left Shoulder	☐ Left Leg	☐ Mid Torso	☐ Right Foot
☐ Left Arm	☐ Right Leg	☐ Mid Back	☐ Left Foot
☐ Left Elbow	☐ Right Shoulder	☐ Right Knee	☐ Other :
☐ Left hand	☐ Right Arm	☐ Left Knee	
☐ Upper Front Torso	☐ Right Elbow	☐ Lower Front Torso	

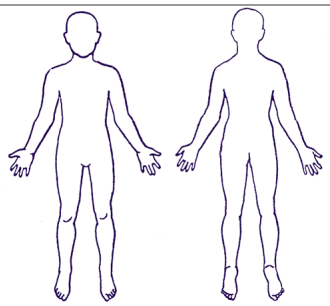
After Accident Information:

Immediately After Accident:	☐ Dizzy/dazed ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Unconscious ☐/Other:

Pain (Indicate if you experienced any pain immediately following the accident)

☐ Head	☐ Left foot	☐ Right foot	☐ Left Knee
☐ Left Hand	☐ Left Shoulder	☐ Right Shoulder	☐ Right knee
☐ Right Arm	☐ Left Elbow	☐ Left Arm	☐ Other :
☐ Upper Front Torso	☐ Mid Torso	☐ Right elbow	
☐ Upper Back	☐ Mid back	☐ Lower Front Torso	
☐ Left Leg	☐ Right Leg	☐ Lower Back	

Numbness:



FRONT BACK (Please indicate areas of numbness)

Medical Information (Did you get medical care for this accident before coming to our office)

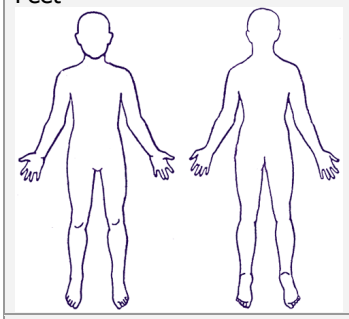
Medical Care?	☐ Yes ☐ No
Time of care	Next day / At time of Accident / Later that Day / Days Later: (Specify)
Transported	Drove Self / Ambulance / Other
Went To	Orthopedic / Chiropractor / Neurologist / Family Doc / ER / Other:(Specify)
Admitted to Hospital?	☐ Yes ☐ No Days Spent in Hospital:

Test:	☐ X-ray ☐ Lab Work ☐ MRI ☐ CT Scan ☐ Other:(Specify)
Treatment:	☐ None ☐Ice Pack ☐Heat ☐Cervical Collar ☐Medication ☐Other:(Specify)

Previous Injuries

Previous Injuries / Accidents	☐ No ☐ Yes, Specify:
Residual pain from Previous Injuries/Accidents	☐ No ☐ Yes, Specify:

Later Symptoms (Please note any symptoms that started after the accident occurred. Use diagram if necessary)

Head	☐ Headache ☐ Dizziness ☐ Blurred Vision ☐ Light Headedness ☐ Loss of Vision ☐ Loss of Consciousness ☐ Loss of Memory ☐ Pain in ear ☐ Double Vision ☐ Other Specify:
Neck (with Movement)	☐ Pain in Neck : ☐ Turning left ☐ Turning right ☐ Bending Left ☐ Bending Right ☐ Looking Down ☐ Looking Up ☐ Popping in Neck ☐ Muscle Spasms
Shoulders	☐ Pain in Shoulder joint ☐ Tension in shoulders ☐ Muscle Spasms in Shoulder ☐ Pain across shoulder ☐ Cant raise arms ☐ Other Specify:
Arms and Hands	☐ Pain in Fingers ☐ Numbness in Left Arm ☐ Hands Cold ☐ Pin & needles in hands ☐ Numbness in Right Arm ☐ Loss of Grip Strength ☐ Pin & needles in fingers ☐ Swollen joints in Fingers ☐ Other Specify:
Chest	☐ Chest pain ☐ Pain Around Ribs ☐ Shortness of Breath ☐ Breast Pain ☐ Other Specify:
Abdomen	☐ Nervous Stomach ☐ Nausea ☐ Diarrhea ☐ Gas ☐ Constipation ☐ Other Specify:
Mid back	☐ Sharp Stabbing ☐ Mid pain back ☐ Dull Ache ☐ Pain in Kidney Area ☐ Muscle Spasms ☐ Pain between shoulders ☐ Other Specify:
Lower Back	☐ Low Back Pain Low back pain is worse when ☐ Working ☐ Lifting ☐ Stooping ☐ Standing ☐ Muscle Spasms ☐ Sitting ☐ Bending ☐ Coughing ☐ Lying Down ☐ Other Specify:
Hips, Legs & Feet 	☐ Pain in Buttocks ☐ Pain and needles in Legs ☐ Pain down leg ☐ Pain in hip joint ☐ Feet feel Cold ☐ Swollen Feet ☐ Numbness in Toes ☐ Numbness of Leg ☐ Knee pain ☐ Leg cramps ☐ Cramps in Feet ☐ Other Specify:
General	☐ Nervousness ☐ Fatigue ☐ Irritable ☐ Depressed ☐ Generally Feel Rundown ☐ Prostate Pain/Swelling ☐ Difficulty Urinating ☐ Night Urination ☐ Cramping ☐ Irregularity Loss of Sleep : [___] hrs per night Weight Loss: [___]lbs Weight Gain: [___] lbs Other:

Signature: _____ Date: _____