PINE MASSAGE THERAPY

SUITE 406 – 1755 WEST BROADWAY VANCOUVER, BC CANADA V6J 4S5 PHONE: **604.739.7988** FAX: **604.714.0053**

MOTOR VEHICLE ACCIDENT INTAKE FORM

Name: _____Date: _____

Claim Number: _____Date of MVA: _____

Adjuster's Name: _____Phone Number: _____

Lawyer's Name: _____Phone Number:_____

Patient was seated: driver's seat, front passenger, rear left, rear right, other: _____

Describe the accident: _____

_____

Did any part of your body make contact with the interior of the vehicle? ___Yes ___No

If Yes, describe contact: _____

Were you looking straight ahead at time of impact? ___Yes___No

If No, describe position: _____

Did you anticipate the accident? ___Yes___No

Was a seat belt used? ___Yes___No Was there a headrest in the vehicle? ___Yes ___No

Did you sustain any seatbelt bruising? ___Yes ___No

AS A RESULT OF THE ACCIDENT, THE PATIENT:

Sustained a loss of consciousness: ___Yes___No If Yes, duration: _____

Complains of neck pain? ___Yes___No

Complains of thoracic pain? ___Yes___No

Complains of low back pain? ___Yes___No

Complains of ___nausea ___sleeplessness ___light headedness ___dizziness ___irritability
___blurred vision ___forgetfulness ___headaches ___ring/buzz in ears ___disorientation

First Aid care was given at? ___hospital ___none ___other: _____

Received any medication? ___Yes___No

If Yes, list medications: _____

Describe any symptoms or injuries not addressed above:

_____

_____

Any change in household or recreational activities? ___Yes ___No

If yes, how has it changed_____

Since accident are you still able to work? ___Yes ___No

If yes, any modifications?_____