Massage Motor Vehicle Accident Form

Name_____ M F Age___ Date_____
Address_____ Postal Code_____
Phone (H)_____ (W)_____ (C)_____

Accident Information
Date of MVA_____ Time of Day_____
Location_____
General Details (please describe) _____
_____
Where you were seated? (ie: driver, passenger, front/back, etc)_____
Did you see the accident coming? Yes NO
Were you wearing your seatbelt? Yes NO
Before the accident, were you looking (circle one):
Straight ahead In rearview mirror To the left To the right
Where was your car hit? (right rear bumper/fender ect..)_____
Were you thrown around or did you hit anything during impact? _____
Describe_____
Was an ambulance called for you? _____ Did you go to the hospital? _____
Did you see a doctor for your injuries? _____ Dr.'s Name_____
How long after?_____
Did you feel any pain right after the accident?_____
Did you sleep well the first night? _____
How did you feel the next day? _____
Were you prescribed medications? ____ Are you still taking any? _____
Did you miss any work or go on light duty? _____ How long? _____
Describe your current symptoms _____
_____
How was your health before the accident? _____
Have you received any other treatments for your injuries? _____

Insurance Information

Insurance Company _____ Policy/Claim # _____
Address _____Postal Code _____
Adjuster's Name _____ Phone _____
Fax _____
Is your insurance company aware that you are receiving massage therapy? _____
Is this a Section B Claim? _____
Do you or your spouse have any health insurance or benefit plan? _____
Details _____