YOUR CENTRES FOR SPINAL, SPORTS AND OCCUPATIONAL REHABILITATION

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MVA ACCIDENT HISTORY

Client Name: ____

1. You were: ☐ Driver ☐ Passenger (front seat) ☐ Passenger (back seat)
2. Were you wearing a seatbelt? ☐ Yes ☐ No
3. Type of collision: ☐ Rear-end ☐ T-hit (side) ☐ Head-on ☐ Roll over
4. Head position at time of impact: ☐ Straight ahead ☐ Looking right ☐ Looking left
5. Did you have immediate symptoms at the exact moment of impact? ☐ Yes ☐ No
6. Do you recall hitting your head inside the vehicle ☐ Yes ☐ No
7. Did you suffer any loss of consciousness at the time of the collision? ☐ Yes ☐ No
8. Were you prepared for the impact? ☐ Yes ☐ No
9. If your symptoms were not immediate, how soon after the accident did they begin? ____ Min _____ Hours ____ Days
10. Did you see a Medical Doctor immediately: ☐ No ☐ Yes (Emergency) ☐ Yes (Walk-in clinic) ☐ Yes (Family Doctor)
11. Have you seen any other health care practitioners as result of your current injury? ☐ No ☐ Yes

    ☐ Chiropractor # of visits: ____________
    ☐ Massage Therapist # of visits: ____________
12. Have any of these other health care practitioners completed and AB-2 Treatment Plan Form: ☐ No ☐ Yes
13. Have you seen any other specialists as a result of your injuries?
    ☐ Orthopaedic Surgeon ☐ Rheumatologist ☐ Neurologist ☐ Physiatrist
14. Are your currently employed ☐ Yes ☐ No Are you currently working? ☐ Yes ☐ No
15. Have you had a previous motor vehicle accident? ☐ Yes ☐ No
16. If yes, did you receive Physical Therapy? ☐ Yes ☐ No