DR.ATOOSA
CHIROPRACTOR
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P: (416) 222-7775
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St. Gabriel Medical Centre
650 Sheppard Avenue East
North York, ON M2K 3E4

CONFIDENTIAL MVA INTAKE FORM

ACCIDENT INFORMATION

Date of Accident _____Time _____❒ AM ❒ PM

Location _____Car Insurance Company _____

Address _____ Phone _____

Fax _____ Claim# (if known)_____ Name of Adjudicator (if known) _____

Have you reported the accident to your insurance company? ❒YES ❒NO

Do you have extended health insurance? ❒YES ❒NO Name of Company _____

Policy # _____ Phone _____

Describe the accident details (including road conditions, direction travelling, etc.)

_____
_____
_____
_____
_____
_____

What symptoms have you noticed since the accident?

_____
_____
_____

Did you suffer from any pain prior to the accident? ❒YES ❒NO Where? _____

ACCIDENT DETAILS

What limitations have you noticed since the accident?	❑ Can't lift ❑ Can't clean ❑ Can't cook ❑ Can't look after children	❑ Can't study ❑ Can't sit for long ❑ Can't concentrate ❑ Can't work ❑ Other
Were you employed at the time of the accident?	❑ Yes ❑ No	Where? Job Title? Duration?
Have you lost any days from work?	❑ Yes ❑ No	Duties / Job demands:
Were you attending school at the time of the accident?	❑ Yes ❑ No	
Did you miss any school as a result?	❑ Yes ❑ No	
Do you have any dependents?	❑ Yes ❑ No	Do you have problems with housekeeping?

Continued…

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ACCIDENT DETAILS *cont'd*

Do you have an attorney advising you on this case?	❑ Yes ❑ No	Name Phone
Describe the damage to your car		
Describe the damage to the other vehicle(s)		
Were you the	❑ Driver ❑ Passenger ❑ Rear driver's side	❑ Rear passenger's side ❑ Pedestrian ❑ Cyclist
Were there any other persons in the car?	❑ Yes ❑ No	Were they injured? ❑ Yes ❑ No
How were you struck?	❑ Rear-ended ❑ Side/T-boned ❑ Head on	❑ Left side ❑ Right side
What is the model of your car?		
What was the speed at impact? Km/hr		
Did you suffer from either other the following?	❑ Loss of consciousness ❑ Amnesia	
Did you go to the hospital as a result of the accident?	❑ Yes ❑ No	Which hospital?
Did you require an ambulance to get to the hospital?	❑ Yes ❑ No	Doctor's Name
How long did you stay?		X-rays taken? ❑ Yes ❑ No Results:
Have you visited a medical doctor since the accident?	❑ Yes ❑ No	Doctor's Name
Was there an investigation or prescriptions?	❑ Yes ❑ No	
Were you wearing your seatbelt?	❑ Yes ❑ No	Air Bags Deployed? ❑ Yes ❑ No

PLEASE READ AND SIGN THE FOLLOWING

The above statements are true to the best of my knowledge.
If for any reason the insurance will not accept or discontinue my claim, I am responsible for all charges.

Signature: _____ Date: _____

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CONFIDENTIAL PSYCHOLOGICAL SCREENING QUESTIONNAIRE

The use of this form is for referral purposes only and will be kept strictly confidential.

Name: _____

Please check the box if you have experienced any of the following since your motor vehicle accident?

►Any nervousness driving or being a passenger in a vehicle? □Yes □ No

►Difficulty coping with a pain condition and/or emotional difficulties which have affected ones ability to function within your respective home, social or occupational environment? □Yes □ No

►Sleep disturbances (lack of sleep, trouble initiating sleep, and/or trouble maintaining sleep) as a result of functional, emotional, and/or interpersonal difficulties? □Yes □ No

►Anxiety represented by increased arousal, nightmares, flashbacks, constant thoughts, avoidance and/or agitation? □Yes □ No

►Experiencing any mood or personality disturbances related to an accident, current situation, or current limitations (irritability, agitation, depression, anxiety, relationship difficulties, etc.)? □Yes □ No

►Disengagement from regular activity levels causing distress? □Yes □ No

►Suicidal ideation and/or significant emotional instability? □Yes □ No

Have you been seen for a psychological assessment related to this accident? □Yes □ No

INITIAL _____ DATE: _____