ACTIVEREHAB CENTRE

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MVA INTAKE FORM

PLEASE HAVE A PIECE OF PHOTO ID, YOUR INSURANCE CARD, READY & HAND THEM TO THE RECEPTIONIST WHEN YOU ARE FINISHED

PATIENT INFORMATION		
*Last name:	*First name:	Middle name:

MVA INSURANCE INFORMATION		
Name of the MVA insurance company:		
Address of the MVA insurance company: 12345 STREET ADDRESS UNIT # CITY PROVINCE POSTAL CODE		
Adjuster Name:	Adjuster Phone no.:	Adjuster Fax no.:
Policy no.:	Claim no.:	

*Relationship to Policy Holder:
(Circle one)

Self Spouse Child

Other: _____

If the holder is someone other than Self:

*Last name:	*First name:

ACCIDENT INFORMATION

*DOL:
(Date of accident)

Month: Date: Year:

*Please provide a brief description of how the accident occurred:

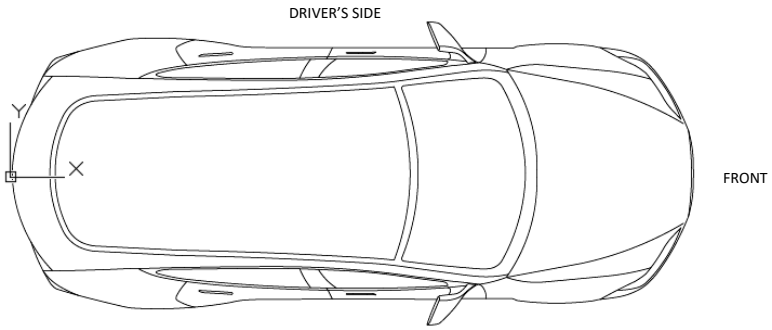
*You were:

☐ The Driver ☐ A Passenger ☐ On a Motorcycle ☐ Riding a Bicycle ☐ A Pedestrian

Where were you seated?:

☐ Driver's Seat ☐ Front Passenger ☐ Rear – Left ☐ Rear – Right ☐ Rear – Middle

Where was your vehicle impacted?:
(Please circle or mark the appropriate area)



What were the weather conditions?:

☐ Clear ☐ Wet ☐ Snow ☐ Icy

Did you hit your head?:	Did you lose consciousness?:	Were you able to get out unassisted?:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Have you received treatment for this injury?:

☐ No ☐ Yes – if yes, what & where?

_____

Are you currently receiving treatment from another health care professional?:

☐ No ☐ Yes – if yes, what?

_____

Have your injuries during this accident affected your:

☐ Work ☐ Recreational Activities/Sports ☐ Home Life ☐ Sleep

Are you currently taking any medications?:

☐ No ☐ Yes – if yes, what? _____

Have you had any prior collisions?:

☐ No ☐ Yes – if yes, when?

_____

Have you had any other major injuries or surgeries?:

☐ No ☐ Yes – if yes, what & when?

_____

SYMPTOMS			
Please check all that apply:	**BEFORE** the collision	**IMMEDIATLEY AFTER** the collision	**CURRENTLY** experiencing
Neck pain and/or stiffness			
Shoulder or Arm pain and/or stiffness			
Arm or Hand weakness and/or tingling			
Upper Back pain/stiffness			
Mid Back pain/stiffness			
Lower Back pain/stiffness			
Hip or Leg pain/stiffness			
Headaches			
Jaw, Tooth, or **Ear** pain			
Loss of co-ordination			
Dizziness			
Vision affected			
Ringing in the ears and/or **Hearing loss**			
Difficulty swallowing and/or **Speaking**			
Nausea and/or **vomiting**			
Trouble concentrating and/or **Memory loss**			
Sleep and/or **Personality Changes**			
Numbness, where: _____			
Other: _____			

AGREEMENT

The above information is true to the best of my knowledge. I acknowledge that any treatment fees not covered by the MVA insurance will be my responsibility. I authorize Active Rehab Centre or the insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date