Waterland Wellness
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MOTOR VEHICLE ACCIDENT (MVA) QUESTIONNAIRE

Patient Name:_____Phone:_____
Date of Birth:_____

PATIENT'S CAR INSURANCE / ATTORNEY (if applicable)

Insurance Name & Address:_____
Insurance Adjustor Name & Phone#:_____
Date of Accident:_____Claim#:_____
Attorney Info (Name/Address/Phone/Fax/Email):_____
_____
_____

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ACCIDENT INFORMATION
Were you the DRIVER or PASSENGER?_____
_____
Were you wearing your seatbelt? Y or N
What kind of vehicle (MAKE/MODEL) were you in?_____
_____
What vehicle (MAKE/MODEL) was the other party driving?_____
_____
How fast were you going approximately?_____Other vehicle?_____
What was the time of the accident & what were the ROAD and WEATHER conditions?_____
_____
_____
Were you seen by a physician/chiropractor/etc.? Y or N
If yes, by whom, and what was the date of first visit related to the MVA?_____
_____
Initial symptoms, if any, related to MVA?_____
_____
Any Activities of Daily Living (ADL's, i.e. trouble sitting/hard to clean the house) affected since the MVA?
_____
_____
What self-care have you done for yourself, if any, since the MVA?_____
_____
In your own words, please describe the accident:_____
_____
_____
_____