NEW MOTOR VEHICLE ACCIDENT FORM

Today's Date _____

Personal Information

Last Name: _____ First Name: _____

Date of Birth: _____ Male: ◯ Female: ◯

Occupation: _____

Accident Information

Date of Accident: _____

Claim #: _____ **Adjuster's Name:** _____ **Phone #:** _____

Lawyer's Name: _____

Mailing Address: _____

Phone #: _____ **Fax #:** _____

Last Car Accident Date (s): _____ **Previous Areas of Injury:** _____

Were you fully Recovered from previous injuries? **Yes** ◯ **No** ◯

Date and Time of Accident: _____

Direction of Travel: _____

Traveling on: _____

Intersection of: _____

I was:

a) **Rear Ended** ☐
b) **T-Boned** ☐
c) **Side Swiped** ☐

Please Mark X on the correct answer:

In this MVA were you the: **The Driver** ☐ **The Passenger** ☐ **A Pedestrian** ☐

Did you require hospitalization? **YES** ☐ **NO** ☐

I was unable to drive car away ☐

I was able to drive car away ☐

I went to Emergency **YES** ☐ **NO** ☐ **If yes, via ambulance?** **YES** ☐ **NO** ☐

I had X-rays in Emergency ☐

I was given medication at Emergency **YES** ☐ **NO** ☐

Seat Belt On	**YES** ☐	**NO** ☐
Air Bag Deployed	**YES** ☐	**NO** ☐
Head Rest Up	**YES** ☐	**NO** ☐
Loss of Consciousness	**YES** ☐	**NO** ☐

Symptoms

How did you feel after the impact/ injury? Please Rate your Pain _____

_____

_____

How do you feel today? Please compile a complete list and rate your symptoms/complaints:

Your primary concern is

On the line provided, please mark where your pain level is today

0 1 2 3 4 5 6 7 8 9 10

No Pain **Most Pain**

Are there any areas of numbness? **YES ☐ NO ☐ Where?**

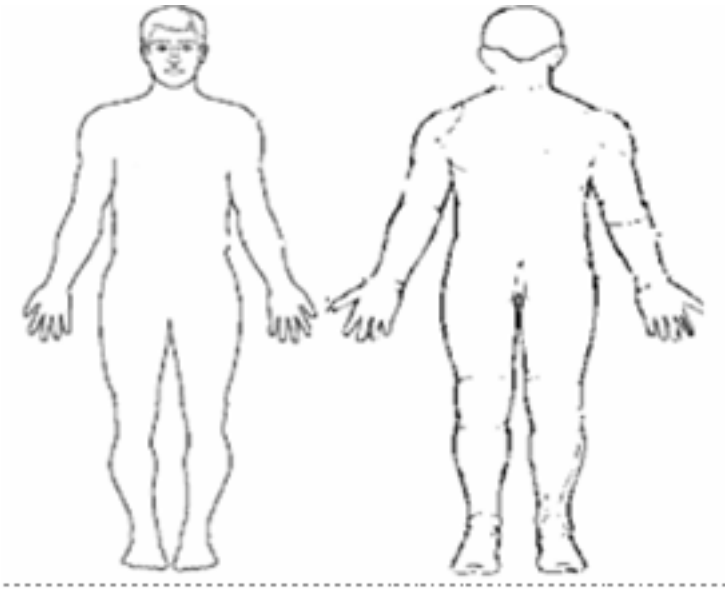
Are there any areas of tingling? **YES ☐ NO ☐ Where?**

Have you had anything like this ever before? **YES ☐ NO ☐ Where?**

What makes your symptom worse?

What makes your symptoms better?

Please mark X, on the drawing below, the areas where you feel pain.
Please mark 0, on the drawing below, the areas where you have numbness.



How has this accident affected your Personal life? If so in what way?

How has his accident affected your Work life? If so in what way?

Do you have a past history of any mental health issues? If so, what?