Leduc Wellness Centre
Motor Vehicle Accident Form

Today's Date: _____ Date of Accident: _____

Patient Name: _____ **Date of Birth: _____**

Insurance Company: _____ **Adjustor/Contact Name: _____**

Policy: _____ **Phone: _____**

Claim: _____ **Fax: _____**

Email: _____

Please describe the accident in your own words: _____

_____

_____

Were you: ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Pedestrian

Type of vehicle (eg. truck, car, small, mid-size): Yours? _____ Other? _____

Seatbelt: ☐ Yes ☐ No Shoulder belt: ☐ Yes ☐ No Headrest: ☐ Yes ☐ No

Were you aware that you were going to have an accident/impact? ☐ Yes ☐ No

Were you struck from: ☐ rear ☐ front ☐ left side ☐ right side

What direction/way were you looking when you had impact? _____

Was your foot on the gas or brake during impact? ☐ Yes ☐ No

Did you strike any portion of your body on the vehicle? ☐ Yes ☐ No

If yes, describe: _____

Describe how you felt (especially pain and where):

During the accident? _____

Immediately after the accident? _____

Later that day? _____

The next day? _____

Please circle the intensity of pain you are experiencing: (best) 1 2 3 4 5 6 7 8 9 10 (worst)

Have you seen another health care professional (eg. physiotherapist, medical doctor)? ☐ Yes ☐ No

If yes, who and where? _____

What testing, if any? _____

Treatment recommended or received? _____

List any medications you are taking: _____

Have you lost time from work/school due to the accident? ☐ Yes ☐ No

If yes, indicate amount of time lost: _____

Occupation and Employer: _____ Full or part-time? _____

What job duties or activities of daily living are you unable to perform? _____

_____

Is there anything else you would like us to know? _____

_____