COCHRANE SPORT PHYSIO

COCHRANE PHYSIOTHERAPY & MASSAGE
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MOTOR VEHICLE ACCIDENT ASSESSMENT FORM

Name: _____ Sex: M / F Age: _____

Today's Date: _____ Date of Injury: _____

Treating Doctor: _____ Dr.'s Phone #: _____

Occupation: _____ Full Time ☐ Part Time ☐

I am currently working: Full Duties ☐ Modified Duties ☐ Not Working ☐

Full Hours ☐ Modified Hours ☐ _____ hours/day

I was off work for _____ weeks. I plan to return to work (dd/mm/yy) ____ / ____ / ____

Check the correct response describing you at the moment of impact:

I was the Driver ☐ Passenger ☐

I was sitting in the Front ☐ Back ☐ Left ☐ Center ☐ Right ☐

I was wearing a seatbelt Yes ☐ No ☐

There was a headrest positioned behind my head Yes ☐ No ☐ Unknown ☐

My head was facing Forward ☐ Turned right ☐ Left ☐ Unknown ☐

My body was facing Forward ☐ Turned right ☐ Left ☐ Unknown ☐

I hit my head Yes ☐ No ☐ Area of Contact: _____

I lost consciousness Yes ☐ No ☐ Length of Time: _____

At the moment of impact, my vehicle was Stopped ☐ Moving ☐ Approx. Speed _____ km/h

The type of impact that happened to my vehicle was

Rear-End ☐ Head-On ☐ T-Bone ☐ Roll-Over ☐

The location of damage to my vehicle was Front ☐ Back ☐ Right ☐ Left ☐

I was driving a Car ☐ Truck ☐ Van ☐ Motorcycle ☐ Other: _____

I collided with a Car ☐ Truck ☐ Van ☐ Motorcycle ☐ Other: _____

The damage to my vehicle was < $1000 ☐ > $1000 ☐

Has a lawyer been contacted? Yes ☐ No ☐

Describe how the accident occurred in the space provided or any other important details about the accident

_____

_____

_____

I left the accident In an Ambulance ☐ Driving My Own Vehicle ☐ With Friends/Family ☐

When after the accident did you seek medical attention? _____

Where did you go? _____

If known, list Doctor's name _____

Please list the initial treatment and instructions provided _____

_____

Please list medication given initially _____

Were x-rays taken? Yes ☐ No ☐ Were you informed of any fractures? Yes ☐ No ☐

List all injuries and ongoing problems, which resulted directly from your accident.
1.
2.
3.
4.
5.

Do you suffer from any numbness or tingling? Yes ☐ No ☐ Where? _____

_____

Have you been involved in any other motor vehicle accidents? Yes ☐ No ☐

If yes, please give dates _____

List all allergies _____

Please indicate with an X if you have any of the following conditions:

High blood pressure		Pregnancy		Asthma or eczema		Previous Fractures	
Diabetes		Stroke		Bleeding disorder		Previous Surgery	
Osteoarthritis		Hernia		Multiple sclerosis		Gout	
Rheumatoid arthritis		Cancer		Mental illness		Disease of ear, eye, nose throat	
Unexplained weight loss		Epilepsy		Bronchitis or lung disease		Heart disease, heart attack	

Please list any other conditions that you have or have had:

Do you have help at home? Yes ☐ No ☐ Married? Yes ☐ No ☐ Children? Yes ☐ No ☐

Please list activities that you usually participate in _____

Do you suffer from headaches? Yes ☐ No ☐ Describe location on head _____

Describe sensation in head _____

How often do they occur? _____ What decreases headache? _____

What activities seem to increase headaches? _____

_____

Did you suffer from headaches prior to your motor vehicle accident? Yes ☐ No ☐

Have you been diagnosed with migraine headaches? Yes ☐ No ☐ Treatment _____

Any previous head trauma? Yes No Explain _____

List any previous treatment that you have received for this injury _____

_____

List any ongoing treatment you are receiving currently _____

_____

How has previous treatment altered your symptoms? _____

_____

List medical specialists who have assessed you _____

_____

List other medical tests (i.e. MRI) and results _____

_____

List current medications _____

_____

_____

The above information is true to my knowledge Yes ☐ No ☐

I give consent to be assessed and receive physiotherapy treatment Yes ☐ No ☐

Signature _____ Date _____