

MVA appointments: Please fill out as complete and detailed as possible

Date: _____
 Name: _____
 Date of Birth: _____
 Telephone number: _____
 Address: _____
 Family Doctor: _____
 Date of accident: _____
 Time of accident: _____
 ICBC claim number: _____
 Name of adjuster: _____
 Adjuster's phone number: _____
 Location of accident: _____

Please circle the correct answer for the following questions.

What seat did you occupy? **Driver** **Front Passenger**
 Behind Driver Back Centre Back Passenger

Were you wearing your seatbelt?	Yes	No
Did the airbag deploy?	Yes	No
Did the ambulance attend the MVA site?	Yes	No
Do you have any immediate injury or pain?	Yes	No
Did you go to the hospital?	Yes	No
If yes, which hospital?	_____	
Were any tests or x-rays ordered?	Yes	No
Did you visit any other clinic?	Yes	No

Pre-existing problems: _____

Are you taking any medications related to the accident pains? _____

Describe how the accident happened? _____

Shade areas on figure where you were injured?

Have you missed any work? Yes No
 Have you missed any school? Yes No

What normal activities are you now unable to do or have difficulty with as a result of the accident? _____

