RIVER STONE
Massage & Wellness Centre

Date ____________________

Motor Vehicle Accident (MVA) Form

Name: ____________________ ❐ Male ❐ Female
Address: ____________________ City: ____________________ Postal Code: ____________
Email: ____________________ Home Phone: ____________________
Birth Date: ____________________ Email: ____________________
Medical Doctor: ____________________
Doctor Phone #: ____________________ AB #: ____________________

Accident Information
Date of MVA: ____________________ Time of Day: ______________ Location: ____________________
General accident details: ____________________
Did you see the accident coming? ❐ Yes ❐ No Were you wearing a seatbelt? ❐ Yes ❐ No
Before the accident were you looking... ❐ straight ahead ❐ rearview mirror ❐ to the left ❐ to the right
Where was your car hit? (right rear bumper, passenger side, etc) ____________________
Did you hit anything on impact? ❐ Yes ❐ No Describe: ____________________
Was an ambulance called for you? ❐ Yes ❐ No Did you go to the hospital after the accident? ❐ Yes ❐ No
Did a doctor assess your injuries? ❐ Yes ❐ No How long after? _______ Dr.'s name: ____________________
Did you feel any pain right after the accident? ❐ Yes ❐ No Did you sleep well the first night? ❐ Yes ❐ No
How did you feel the next day? ____________________
Were you prescript medications? ❐ Yes ❐ No Which one(s)? ____________________
Are you still taking them? ❐ Yes ❐ No Which one(s)? ____________________
Did you miss any work or go on light duty? ❐ Yes ❐ No How long? ____________________
Describe your current symptoms: ____________________
____
How was your health before the accident?: ____________________
Have you received any other treatment for your injuries?: ❐ Yes ❐ No Where? ____________________

Insurance Information
Insurance Company: ____________________ Policy/Claim #: ____________________
Address: ____________________ Postal Code ____________________
Adjuster's Name: ____________________ Phone: ____________________
Email: ____________________ Fax: ____________________
Is your Insurer aware you are receiving massage therapy? ❐ Yes ❐ No Is this a Section B Claim? ❐ Yes ❐ No
Do you or your spouse have any health insurance or benefit plans? ❐ Yes ❐ No Details: ____________________