AUTOMOBILE ACCIDENT HISTORY FORM - MVA

NAME _____ DATE (DD/MM/YY) _____

DATE OF ACCIDENT _____ CLAIM # _____

1) Briefly describe the accident: _____

_____

2) Road condition at the time of the accident: ❍ Wet ❍ Dry ❍ Icy ❍ Other _____

At the time of impact,

a) was your car: ❍ Stopped ❍ Slowing down

b) was the other vehicle: ❍ Stopped ❍ Slowing down ❍ Gaining speed ❍ At a constant speed

3) Did you go to a hospital? ❍ Yes ❍ No

IF YES, PLEASE NAME _____ HOW LONG? _____

a) Did you sustain: ❍ Bleeding ❍ Cuts ❍ Bruises ❍ None

b) What did the hospital do for your injuries? _____

c) Were you taken by ambulance? ❍ Yes ❍ No

4) Where were you seated in the vehicle? ❍ Yes ❍ No

5) Were you wearing a lap belt and a shoulder harness? ❍ Yes ❍ No

6) Was your head rest in its proper position (ie. Positioned at the back of the skull)? ❍ Yes ❍ No

7) Was the air bag deployed upon impact? ❍ Yes ❍ No

8) Did you brace yourself prior to impact? ❍ Yes ❍ No

9) Were you looking in any direction prior to impact? _____

(ie. Rearview mirror, to the side, into the back seat, adjusting radio, etc)

10) Were you sitting straight or twisted in your seat prior to impact? _____

11) Did you lose consciousness (black out) upon impact? ❍ Yes ❍ No

IF YES, HOW LONG? _____

12) Did any part of your body strike the interior of the vehicle? ❍ Yes ❍ No

13) Were you able to get out of your vehicle on your own? ❍ Yes ❍ No

14) Did you experience a flash of light or explosion in your head? ❍ Yes ❍ No

15) Was there damage to the vehicle? ❍ Yes ❍ No

IF YES, PLEASE DESCRIBE _____

16) Have you seen your general practioner? ❍ Yes ❍ No

WHAT WAS DONE THERE? _____

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17) Have you had any other type of treatment? ❍ Yes ❍ No

PLEASE DESCRIBE

18a) Are you taking any prescribed medications now? ❍ Yes ❍ No

Type _____ Quantity _____ Type _____ Quantity _____

a) Are you taking any prescribed medications now? ❍ Yes ❍ No

Type _____ Quantity _____ Type _____ Quantity _____

19a) Are you taking any over the counter medications now? ❍ Yes ❍ No

Type _____ Quantity _____ Type _____ Quantity _____

b) Did you take any over the counter medicines after the accident: ❍ Yes ❍ No

Type _____ Quantity _____ Type _____ Quantity _____

Please check any of the following symptoms you have experienced since the accident:

- ❍ Neck pain
- ❍ Neck stiffness
- ❍ Shoulder pain
- ❍ Headache
- ❍ Pain between the upper shoulders
- ❍ Upper extremity numbness &/or tingling
- ❍ Mid back pain
- ❍ Rib pain
- ❍ Abdominal pain
- ❍ Low back pain
- ❍ Lower extremity numbness &/or tingling
- ❍ Lower extremity weakness
- ❍ Lower extremity pain
- ❍ Dizziness
- ❍ Hoarseness
- ❍ Jaw noise (clicking, popping, cracking)
- ❍ Jaw locking
- ❍ Squinting of the eyes
- ❍ Eyes tearing
- ❍ Flushing
- ❍ Salivation
- ❍ Runny nose
- ❍ Difficulty swallowing
- ❍ Decreased concentration
- ❍ Impaired logical thought
- ❍ Impaired memory
- ❍ Lightheadedness
- ❍ Sensitivity to light
- ❍ Hearing change
- ❍ Blurred vision
- ❍ Sensitivity to sound
- ❍ Facial pain
- ❍ Pulling sensation behind eyes
- ❍ Nausea
- ❍ Fatigue easily
- ❍ Mood changes
- ❍ Personality change
- ❍ Irritability
- ❍ Depression
- ❍ Loss of libido
- ❍ Insomnia

20) Do you have any previous history of the above symptoms prior to this accident? ❍ Yes ❍ No

IF YES, DESCRIBE

21) Do you have any additional information that you would like to inform us of?

Release Statement

I understand that my case is subject to review and possible rejection by the Saskatchewan Government Insurance and that this office will prepare any necessary reports and forms that will assist me in securing my claim from SGI. I further understand that should my claim be rejected by Saskatchewan Government Insurance, I will be responsible for all services and charges rendered to me.

PATIENT SIGNATURE

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