Cold Lake Physiotherapy Clinic
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MVA Questionnaire

Patient's Name: _____

1. You were: Driver Passenger (front seat) Passenger (back seat)
2. Were you wearing a seatbelt? Yes No
3. Type of collision: Rear-end T-hit (side) Head-on Roll over
4. Head position at time of impact: Straight ahead Looking right Looking left
5. Did you have immediate symptoms at the exact moment of impact? Yes No
6. Do you recall hitting your head inside the vehicle? Yes No
7. Did you suffer any loss of consciousness at the time of collision? Yes No
8. Were you prepared for the impact? Yes No
9. If your symptoms were not immediate, how soon after the accident did they begin?

____ ____ ____
Min Hours Days

10. Did you see a Medical Doctor Immediate:
No Yes (Emergency) Yes (walk-in-clinic) Yes (Family Doctor)
11. Have you seen any other health care practitioners as a result of your current injury?
No Yes
Chiropractor # of visits: _____
Massage Therapist # of visits: _____
12. Have any of these other health care practitioners completed and AB-2 Treatment Plan Form: No Yes
13. Have you seen any other specialists as a result of your injuries?
Orthopaedic Surgeon Rheumatologist Neurologist Physiatrist
14. Are you currently employed Yes No Are you currently working? Yes No
15. Have you had a previous motor vehicle accident? Yes No
16. If yes, did you receive Physical Therapy? Yes No

Patient's Signature _____ Date_____