Total Balance PHYSIOTHERAPY

Bracebridge – 2-36 McDonald Street
P: (705) 646-2299 F: (705) 646-2709
Gravenhurst – 241 Brock Street
P: (705) 640-2299 F: (705) 640-2709

MVA Information Form

Name:_____ Mr / Mrs / Ms
Date:_____ D/M/Y
Motor Vehicle Insurance Company:_____
Policy #:_____ Claim #:_____
Policy Holder: Claimant □ OR Other:_____

Have you seen any other health professional regarding this accident? I.E Chiropractor, Massage Therapist, Physiotherapist, Occupational Therapist.
YES_____NO_____
Details:_____

Total Balance Physiotherapy has my consent to contact my insurance company (automotive or private) regarding any information pertaining to this claim. Signature:_____

By Law Motor Vehicle Accident Benefits will only pay for treatment that is not covered by any other private policy or employment benefit plan. If these other benefit plans cover only part of the expenses, accident benefits will (upon approval) pay the balance.

Are you covered for Physiotherapy under any other insurance plan ?
YES _____ NO _____
Private Insurance Company:_____
Policy #:_____ Plan Member #:_____
Policy Holder: Claimant □ OR Other:_____

Please fill in the details regarding the accident.

Accident:
Date_____(dd/mm/yyyy)
Time_____

Type:
Car-Car □ Car-Object □
Car-Pedestrian □
Other:_____

Upcoming Impact :
Aware □ Unaware □

Collision (your vehicle):

Front	□	Left	□
Front-Right	□	Rear-Right	□
Front-Left	□	Rear-Left	
Right	□	Rear	□

Seating:

Driver	□	Passenger	□
Left back	□	Right Back	□

Please continue on the other side.

Vehicles: **Your** **Other**

Subcompact	□	□
Compact	□	□
Midsize	□	□
Full-size	□	□
Pickup	□	□
Van	□	□

Other:_____

Position at Impact:

Looking ahead □ Looking right □
Looking left □

Impact Speed

Patient _____
Other _____

Restraints:

Belt On □
Headrest
None □
Fixed □
Mobile □
Up □
Down □

Impact: **You** **Other**

Stopped	□	□
Slowing	□	□
Gaining speed	□	□
Steady speed	□	□

Car after Impact:

Stopped □ Moved ahead □
Spun □ Hit another car □
Hit object □

Contact/Trauma: (connect with a line)

Face	Windshield
Head	Steering wheel
Neck	Door
Chest	Dash
Shoulder	Frame
Arm	Other Person
Hip	Seat
Leg	Seat Belt

Other:_____

Pain:

Immediate □
Or
_____ hours later □
_____ days later □

Return to Work:

No loss □
_____ days □
_____ weeks □
Unable to return □

Type of Work:_____
_____
_____
_____
_____

Post-Impact:

Loss of conscousness □
Went to Emerg? □
Hospital_____
Date_____
Time_____
Walked □
Drove self □
Driven □

X-RAYS:

Neck □ Head □
Arm/Leg □ Back □

Medications for:

Pain □ Swelling □
Spasm □

Supports:

Collar □ Brace □

Stitches □

Symptoms:

Pain □ Dizziness □
Nausea □ Visual □
Balance □ Coordination □
Numbness □
Ringing in the ear □
Other □:_____
_____
_____