Motor Vehicle Accident (MVA) Report

Name: _____ Today's Date: _____

Occupation: _____

Date of MVA	Time	AM / PM	Weather
Where did the accident occur?			

Your Vehicle	Other Vehicle
Sedan ☐ SUV ☐ Van ☐ Other ☐:	Sedan ☐ SUV ☐ Van ☐ Other ☐ :
What was the damage to your vehicle?	What was the damage to the other vehicle?
What was your approximate speed at impact?	What was the speed of the other vehicle?

Were you the driver of the vehicle? Yes ☐ No ☐	How many passengers? 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+ ☐
Were you wearing a lap & shoulder belt? Yes ☐ No ☐	Were the head restraints in the up position? Yes ☐ No ☐
Does your vehicle have airbags? Yes ☐ No ☐	Did your airbags deploy? Yes ☐ No ☐
Where were you sitting in the vehicle? Front ☐ Rear ☐ Right ☐ Left ☐ Center ☐	Where was the impact on your vehicle? Left ☐ Right ☐ Head-on ☐ Rear end ☐ Broadside ☐
Did you tense up before impact? Yes ☐ No ☐	Did you lose consciousness? Yes ☐ No ☐

Please briefly describe the accident:

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Were you able to get out of the vehicle on your own immediately after the accident? Yes ☐ No ☐	Did you receive medical attention by paramedics at the scene of the accident? Yes ☐ No ☐
Did you go to the hospital? Yes ☐ No ☐	If so, how were you transported there? By yourself ☐ Ambulance ☐ Other ☐ N/A ☐
Did you have x-rays? Yes ☐ No ☐	Were you given medication? Yes ☐ No ☐

<u>Symptoms</u> – Please check all that apply:

Head	**Pain**	**Emotional**
☐ Loss of consciousness	☐ Neck	☐ Stomach cramps
☐ Headache	☐ Shoulder	☐ Anxiety
☐ Dizziness	☐ Back	☐ Depression
☐ Blurred vision	☐ Bones / Joints / Muscles	☐ Mood swings
☐ Memory loss	☐ Clicking in the neck or jaw	☐ Fear of driving
☐ Trouble concentrating	☐ Bruises from seat belt	☐ Difficulty sleeping
☐ Other:	☐ Bruises from impact	☐ Other:
☐ Other:	☐ Glass injuries	☐ Other:
☐ Other:	☐ Other:	☐ Other:

Have you ever had similar injuries? Yes ☐ No ☐	If yes, when?
Are you disabled from your job? Yes ☐ No ☐	If yes – explain
Does your employer provide benefits? Yes ☐ No ☐	When do you think you will be able to return to work?
Are you able to do your household activities? (chores, driving, shopping, personal care, child care…) Yes ☐ No ☐	If no – explain
Are you able to participate in leisure activities? Yes ☐ No ☐	Which ones? If no – explain
Any other information you would like to provide?	