

MOTOR VEHICLE ACCIDENT | PRE-ASSESSMENT INFORMATION

Please complete what you can before your initial assessment. If you do not know an answer, leave it blank. Clinical history will be reviewed separately by your practitioner.

1. Client information

Full legal name

Date of birth (YYYY-MM-DD)

Email address

Phone number

2. Accident information

Date of accident (YYYY-MM-DD)

Province / location of accident

Your involvement in the accident

☐

Driver

☐

Passenger

☐

Pedestrian

☐

Cyclist

☐

Other

Briefly describe what happened (1-2 sentences; medical details not required)

3. Automobile insurance information

Auto insurance company

Accident benefits claim number

Auto insurance policy number (if known)

Policyholder name (if different)

Adjuster name (if assigned)

Adjuster telephone

Adjuster email

MOTOR VEHICLE ACCIDENT | PRE-ASSESSMENT INFORMATION

Please complete the remaining questions to help us prepare your insurance records.

3. Automobile insurance (continued)

Has an accident benefits claim been opened?

☐ Yes ☐ No ☐ Not sure

Have you submitted an OCF-1 (Application for Accident Benefits)?

☐ Yes ☐ No ☐ Not sure

4. Other insurance coverage

Do you have extended health benefits (work, spouse/partner, or private plan)?

☐ Yes ☐ No ☐ Not sure

Extended health insurance company (if applicable)

5. Previous treatment related to this accident

Have you received treatment related to this accident?

☐ Yes ☐ No ☐ Not sure

Name of previous treating clinic or provider (if applicable)

Has an insurer approved any assessments or treatment plans for this accident?

☐ Yes ☐ No ☐ Not sure

6. Additional information

Anything else our administrative team should know? (Optional)

Privacy: Information is collected for clinic administration and coordination of your MVA claim.
Contact the clinic directly if you prefer to provide insurer details by telephone.

This form is not an authorization to release health information.