Wolf Chiropractic Clinic
Massage Therapy & Acupuncture

MVA Questionnaire

Patient Name ______________________________ **Date** ______________

Date of Injury/Accident ____

Approximate Location of Auto Accident ____

Type of Collision: ☐ Rear Impact ☐ Head On ☐ Single Car ☐ Roll-Over
☐ Side Impact involving what part of your vehicle?
☐ passenger side ☐ driver's side ☐ front

Did your car hit anything else after it was hit? ☐ Yes ☐ No If yes, please describe: ____________
____

Please describe to the best of your knowledge what happened at the time of the accident:
____
____

What type of vehicle were you in? Year______________ Make ______________ Model ______________

Where were you seated in the vehicle?
☐ Driver ☐ Front Seat Passenger ☐ Rear Seat Passenger on the: ☐driver's side ☐passenger side

Were you wearing a seat belt? ☐ Lap belt and shoulder harness ☐ Lap belt Only ☐ None

What direction were you facing at time of impact?____

Describe the other vehicle: Year_____________ Make ______________ Model ___________________

Is your vehicle equipped with airbags? ☐ Yes ☐ No Did the airbag(s) deploy? ☐ Yes ☐ No

Were you: ☐ Aware of the impending collision ☐ Caught by surprise
Did you brace for the impact?_____________________________

Did you strike anything within the vehicle? ____
If yes, did you have any cuts or visible bruising?______________________________________

Road Conditions: ☐ Dry ☐ Wet ☐ Ice ☐ Snow ☐ Compact Snow/Ice ☐ Other ________

Time of Day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark

At the time of the accident, your vehicle was:
☐ Stopped ☐ Slowing ☐ Accelerating ☐ Steady Rate of Speed

At the time of the accident, the other vehicle was:
☐ Stopped ☐ Slowing ☐ Accelerating ☐ Steady Rate of Speed

Was your car ☐ drivable or ☐ towed from the scene?

Was the other car ☐ drivable or ☐ towed from the scene?

Were the police or State Patrol notified?______________ **Was anyone cited?**___________

AFTER THE ACCIDENT:

Where did you go after the accident?____

Mode of Transportation: ☐ you were able to drive yourself ☐ transported by another individual
☐ transported by ambulance

Who was the first doctor you saw after the accident? ___________________________
Date:_______________ ☐ His/Her Office ☐ ER ☐ Urgent Care

Emergency Department or Urgent Care: ☐ Yes ☐ No Date:_____________ Time:__________

X-rays, CT scans or MRI? ☐ Yes ☐ No
If yes, what body parts were imaged?____

Medication prescribed? ☐ Yes ☐ No ____

Other instructions/treatment rendered: ☐ Ice ☐ Heat ☐ Follow-up with MD ☐ Other

MOTOR VEHICLE INSURANCE INFORMATION

Patient Name: ______________________________________

Date of Accident: ___________________________________

Name of Insured: ____________________________________

1. Your Automobile Insurance Company: ____
   Billing Address: ____
   Policy Number: ____________________________________
   Claim Number: ____________________________________
   PIP Coverage: ______ Yes ______ No
   Agent: _____________________ Phone: ______________ Fax: __________
   Claims Adjuster: _______________ Phone: ______________ Fax: __________
   Verified by: _____________________ Date: _____________

2. Other Parties Insurance Company's Name: ____________________________________
   Complete Billing Address: ____
   Has Clear Liability Been Established? _______ Yes _______ No
   Police Respond? _______ Yes _______ No Was The Tortfeasor Cited? _______ Yes _______ No
   Accident Report Attached? _____ Yes _____ No Requested _____ Yes _____ No Date: ___________
   Tortfeasor/ Responsible Party's Name: ____________________________________
   Tortfeasor/ Responsible Party's Address: __________________________________
   Location of Accident: ____
   Claims Adjuster: _____________________Phone: ______________ Fax: _______
   Verified by: _________________________ Date: _____________

3. Do you have legal representation? _______ Yes _______ No If yes, with whom?
   Name: ________________________ Phone: ___________ Fax: ___________
   Address: ____
   Case Coordinator: ____
   Verified by: ________________________ Date: ______________

4. LIEN FILED? ______ YES ______ NO DR. WOLF APPROVED? ______________________