

NEW WEST WELLNESS
MVA FORM

NAME: _____ **DATE:** _____

DATE OF ACCIDENT: _____ **WHERE IT HAPPENED:** _____

TIME OF ACCIDENT: _____ **CONDITION OF ROAD:** _____

TYPE OF YOUR CAR: _____ **TYPE OF OTHER CAR:** _____

WHO IS AT FAULT FOR THE ACCIDENT? _____

CLAIM #: _____ **ADJUSTERS NAME:** _____

ADJUSTERS PHONE #: _____

LAWYERS NAME: _____

LAWYERS PHONE: _____

(1). BRIEFLY DESCRIBE ACCIDENT:

(2). WHERE WERE YOU SEATED IN THE VEHICLE? _____

(3). WERE YOU WEARING A SEAT BELT? YES or NO

(4). WERE YOU AWARE OF THE ONCOMING ACCIDENT? YES or NO

(5). WHICH WAY WAS YOUR HEAD TURNED AT TIME OF IMPACT?

(6). WAS YOUR CAR MOVING OR AT A COMPLETE STOP AT TIME OF ACCIDENT?

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(7). DID ANY PART(S) OF YOUR BODY HAVE CONTACT WITH IN THE VEHICLE AT TIME OF ACCIDENT? _____

(8). HOW MUCH DAMAGE WAS DONE TO YOUR VEHICLE? \$_____

(9). DID YOU LEAVE THE ACCIDENT BY AMBULANCE? YES or NO

(10). DID YOU SEE A DOCTOR AFTER ACCIDENT? YES or NO
IF YES HOW LONG AFTER? _____

(11). WHAT HURT IMMEDIATELY AFTER THE COLLISION?

- _____
- _____
- _____
- _____
- _____
- _____
- _____

(12). WHAT IS HURTING NOW? (FROM MOST TO LEAST)

- _____
- _____
- _____
- _____
- _____
- _____
- _____

(13) DOCTOR'S NAME _____ **PHONE#** _____

(14). ARE YOU SEEING OTHER PRACTITIONERS FOR THIS ACCIDENT?

1. _____ **PHONE #** _____
2. _____ **PHONE #** _____
3. _____ **PHONE #** _____
4. _____ **PHONE #** _____