VAUGHAN PHYSIOTHERAPY CLINIC

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Scan for your patient portal: book, forms and receipts

Car Accident (MVA) Intake

Get better today.

Treatment after a car accident is approved in blocks. For accidents before July 1, 2026 your extended health plan is billed first; on or after July 1, 2026 your auto insurer is billed first. Please bring your claim number, policy number, driver's licence and any forms you already have.

Patient name *		**Date of birth ***	Y Y Y Y - M M - D D

A. The accident

Date of accident *	Y Y Y Y - M M - D D	**Time**	H H : M M ☐ AM ☐ PM
Where (city / intersection)			
You were the	☐ Driver ☐ Passenger ☐ Pedestrian ☐ Cyclist ☐ Motorcyclist		
Type of collision	☐ Rear-ended ☐ Side impact ☐ Head-on ☐ Rollover ☐ Hit by vehicle ☐ Other _____		
At the scene	☐ Police ☐ Ambulance ☐ Went to ER ☐ Seat belt worn ☐ Airbags deployed		
Areas hurt	☐ Head ☐ Neck ☐ Upper back ☐ Low back ☐ Shoulder ☐ Arm / hand ☐ Hip ☐ Knee ☐ Ankle / foot ☐ Jaw ☐ Chest ☐ Other _____		
Since the accident	☐ Headaches ☐ Dizziness ☐ Trouble sleeping ☐ Anxiety driving ☐ Memory or focus trouble ☐ Numbness / tingling ☐ Other _____		

B. Insurance and claim

Auto insurer *		**Claim # ***	
Policy #		**Policy holder (if not you)**	
Adjuster name		**Adjuster phone**	- -
Adjuster email			
Vehicle make / model		**Extended health plan**	☐ Yes ☐ Through spouse / parent ☐ No
Forms done so far	☐ OCF-1 sent ☐ OCF-3 from doctor ☐ OCF-5 signed ☐ Intact consent ☐ None yet ☐ Other _____		
Lawyer	☐ Yes ☐ No ☐ Thinking about it	**Lawyer name / firm**	
Lawyer phone	- -	**Lawyer email**	

C. Work and daily life

Work since the accident	☐ Off work ☐ Reduced hours ☐ Modified duties ☐ Full duties ☐ Not working before ☐ Student ☐ Retired		
Job title and employer		**Hours per week before**	
Help needed now with	☐ Housework ☐ Childcare ☐ Driving ☐ Self-care ☐ Shopping ☐ Other _____		
Activity you want back (1)		**Score now (0 to 10)**	
Activity you want back (2)		**Score now (0 to 10)**	
Activity you want back (3)		**Score now (0 to 10)**	
Notes for your clinician			

I understand that missed visits without 48 hours' notice may count against my approved treatment, and that the OCF-23 is signed after my first visit.

Signature *		**Date ***	Y Y Y Y - M M - D D