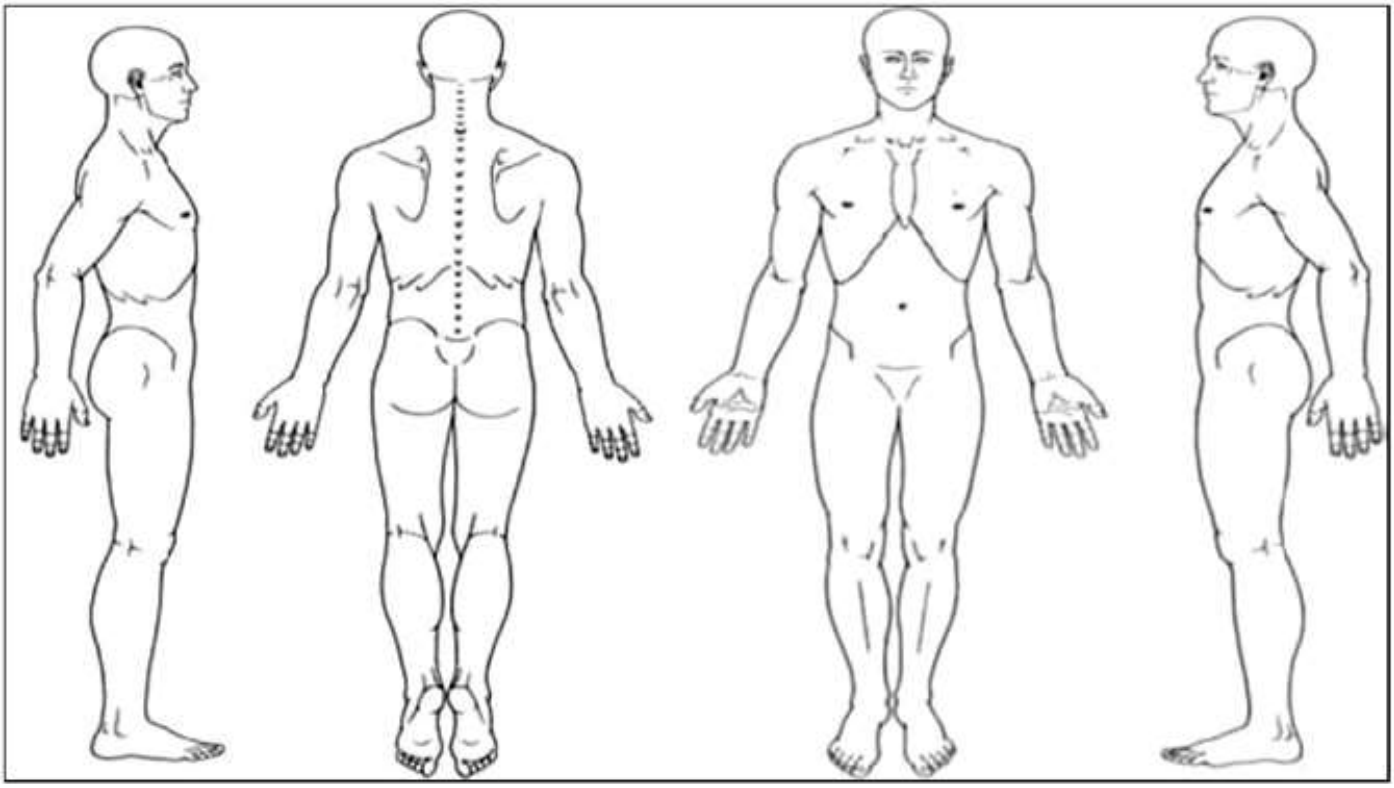
Motor Vehicle Accident – Out of Protocol

Name:	Date of Accident:
Type of Collision:	Damage to Vehicle: $
Do you have Police Report: Y / N	Do you have Extended Insurance Benefits: Y / N

A. Body Diagram: Please mark any symptoms you have had since the car accident.



B. Please check any of the symptom(s) from below that you have experienced.

☐Pain	☐Anxiety or worry
☐Feeling of numbness, tingling in arms or hands	☐Nausea or vomiting
☐Feeling of numbness, tingling in legs or feet	☐Headache
☐Dizziness or unsteadiness	☐Problems concentrating or with memory
☐Vision problems	☐Jaw pain
☐Hearing problems	☐Disturbed Sleep

C. Have the injuries affected your level of function:

☐Daily home activities	Employment (if applicable)
☐School	☐Loss of Income
☐Sports or recreation	☐No loss of income

PHYSIOTHERAPIST NOTES (Please Leave Blank)
