EFFECT THERAPY

CLIENT INTAKE FORM - MOTOR VEHICLE ACCIDENT
ADDITIONAL INFORMATION

Confidential

The information collected on this form is used to help your therapist make an informed assessment and effective treatment plan.
Your personal information is kept confidential.
Records are stored securely for seven (7) years after the last treatment date.

Personal, Claim, & Care Information

Name	(last)	(first)	(initial)
Date of Birth	(month)	(day)	(year)
Address	(full address with postal code)		
Phone	(cell)	(home)	(work)
E-mail Address	(email)		
Vehicle Insurance Company	(name)		(phone #)
Adjuster Information	(name)	(phone)	(email)
Claim Number			
Physician [ ] Primary	(name)	(phone)	(email)
Physiotherapist [ ] Primary	(name)	(phone)	(email)
Chiropractor [ ] Primary	(name)	(phone)	(email)
Permission to Contact and Share Information with Listed Professionals		[ ] Yes	[ ] No

Without permission to contact, we will not be able to invoice your insurance company.

Accident Detail and Personal Injury Information:

Date of Injury/Accident	(month) (day) (year)
Description of Accident	
Current Work Status	[ ] Regular - [ ] Modified - [ ] Leave - [ ] N/A -
Description of Pain/Symptoms	
Level of Pain	1 2 3 4 5 6 7 8 9 10 Mild Pain Scale Severe

MVA Document Checklist:

[ ]	AB1 - Notice of Loss and Proof of Claim
[ ]	AB2 - Treatment Plan (to be completed by your primary health care provider)
[ ]	Effect Therapy - MVA Process Acknowledgement Form
[ ]	Effect Therapy - Client Intake
[ ]	Effect Therapy - Client Intake - MVA - Additional Information (this document)
All documents must be completed in full before MVA massage treatment can begin. Without proper and complete documentation Effect Therapy will be unable to bill your insurance company on your behalf.	

Declaration and Consent

- I declare that the information provided, and all statements made by me on this form are true and complete to the best of my knowledge.
- I understand that the information I have provided will be used to make assessments and create treatment plans.
- I understand that I have the right to refuse and end treatment if at any time I feel unsafe or uncomfortable.

Name_____ Signature_____ Date_____