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Name: \_\_\_\_\_

ICBC Claim #: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_ Adjuster's #: \_\_\_\_\_

Date of the accident: \_\_\_\_\_ Time of the day: \_\_\_\_\_ Speed of my car: \_\_\_\_\_

I was:  wearing my seatbelt  driving  front passenger  back seat left  back seat right

Impacted with another vehicle: \_\_\_\_\_ Where (front/rear/side): \_\_\_\_\_

Describe how the accident happened: \_\_\_\_\_

Did you see the accident coming? \_\_\_\_\_

Did you brace yourself for the impact? \_\_\_\_\_ If yes, how? \_\_\_\_\_

Did your car have headrests? \_\_\_\_\_ What position was the head rest compared to your head? \_\_\_\_\_

Did any part of your body hit any part of the inside of the car? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

Did you lose consciousness? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

Could you move all parts of your body? \_\_\_\_\_ If no, describe: \_\_\_\_\_

Did you get any cuts or bruises from the accident? \_\_\_\_\_ If yes, where? \_\_\_\_\_

How did you feel immediately after the accident: \_\_\_\_\_

Later that day: \_\_\_\_\_

The next day: \_\_\_\_\_

Headaches \_\_\_\_\_ If yes, how often \_\_\_\_\_ per week and are they  tension/  migraine located

forehead/  temple/  back of neck.

Please check all the symptoms that you have experienced since the accident:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Neck Pain             | <input type="checkbox"/> Eyes Light Sensitive | <input type="checkbox"/> Short of Breath     | <input type="checkbox"/> Nervousness      |
| <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Pain Behind the Eyes | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Anxious          |
| <input type="checkbox"/> Shoulder Pain         | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Fatigue          |
| <input type="checkbox"/> Upper Back Pain       | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Depression          | <input type="checkbox"/> Diarrhea         |
| <input type="checkbox"/> Mid Back Pain         | <input type="checkbox"/> Ringing in the Ears  | <input type="checkbox"/> Numbness in Toes    | <input type="checkbox"/> Cold Feet        |
| <input type="checkbox"/> Low Back Pain         | <input type="checkbox"/> Loss of Balance      | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Extremities Pain |
| <input type="checkbox"/> Hip Pain              | <input type="checkbox"/> Loss of Smell        | <input type="checkbox"/> Cold Hands          | <input type="checkbox"/> _____            |
| <input type="checkbox"/> TMJ/ Jaw Pain         | <input type="checkbox"/> Loss of Taste        | <input type="checkbox"/> Constipation        | <input type="checkbox"/> _____            |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Tension              | <input type="checkbox"/> Chest Pain          |   |
| <input type="checkbox"/> _____                 |   |  |   |

**PLEASE TURN OVER**

Have you missed time from work? \_\_\_\_\_

Did you receive treatment immediately after the accident?  Yes  No

By whom (MD/Chiro/Physio/Emergency/RMT/etc.) \_\_\_\_\_

What kind of treatment was given? \_\_\_\_\_

Treatment received by health professionals since accident and present: \_\_\_\_\_

What was your state of health before the accident? \_\_\_\_\_

Prior to the accident, had you ever experienced symptoms similar to those you are experiencing now? \_\_\_\_\_

Do you notice any activities of your home daily routines that are different now than from before the accident?  Yes  No

If yes list any activities you are unable to do, which ones are painful and which ones are difficult to do:

Unable: \_\_\_\_\_

Painful: \_\_\_\_\_

Difficult to do: \_\_\_\_\_

Relative to this MVA injury, how much have you recovered so far? \_\_\_\_\_%

Do you have an attorney on this case? \_\_\_\_ If yes, what is their name and phone # \_\_\_\_\_

**PLEASE NOTE: 24-HOUR CANCELLATION NOTICE IS REQUIRED.** THERE IS A FULL CHARGE FOR LATE CANCELLATIONS OF MISSED APPOINTMENTS. THANK YOU.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_