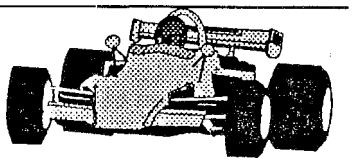
Auto Accident Report Form



Name: _____ Date: _____

1. Date of accident: __ __/__ __/____ 2. Time: _____ AM PM 3. Location: _____

4. Briefly describe how the accident happened: _____

_____

_____

5. Driver of the car:_____ 6. Where were you seated? ◯Front ◯Back

7. Who owns the car? _____ 8. Was a police report made? ◯Yes ◯No

9. Were you wearing a seatbelt? ◯Yes ◯No 10. I was struck from:
◯Drivers side ◯Passenger side ◯Front ◯Rear

11. Were you rotated in the seat? ◯Yes ◯No 12. Direction of your travel _____ Other car _____

13. Where were you looking at impact? ◯Straight ahead ◯Left ◯Right ◯In rear view mirror ◯Behind

14. Was anyone else in the car? ◯No ◯Yes (who?) _____

15. As a result of the accident, were you:
☐Rendered unconscious ☐In shock ☐Dazed, circumstances vague ☐Other: _____

16. Did your car go off the road? ◯No ◯Yes (Did it strike anything?) _____

17. What did you feel *immediately* after the accident? _____

18. What did you feel *later that day*? _____

19. What did you feel *the next day*? _____

20. Where were you taken after the accident? _____

21. What was done for you? ☐X-rays ☐Medication ☐Neck collar ☐Back brace ☐Other _____

22. Have you seen other doctors for this condition? ◯No ◯Yes (Who?) _____

23. Have you had similiar problems in the past? ◯No ◯Yes (describe) _____

24. Have you missed work since the accident? ◯No ◯Yes (when?) _____

25. Have you returned to work? ◯No ◯Yes If yes, full time? ◯No ◯Yes

26. Have you had any previous motor vehicle accidents, personal injury or work injuries? ❑ No ❑ Yes (describe)

_____

27. Did any part of your body strike anything in the car? ◯No ◯Yes (describe) _____

28. How fast would you estimate you were going at time of impact? _____ m.p.h. Other car _____ m.p.h.

29. Do you have an attorney on this claim? ◯No ◯Yes (who?) _____

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30. Check the symptoms apparent since the accident:

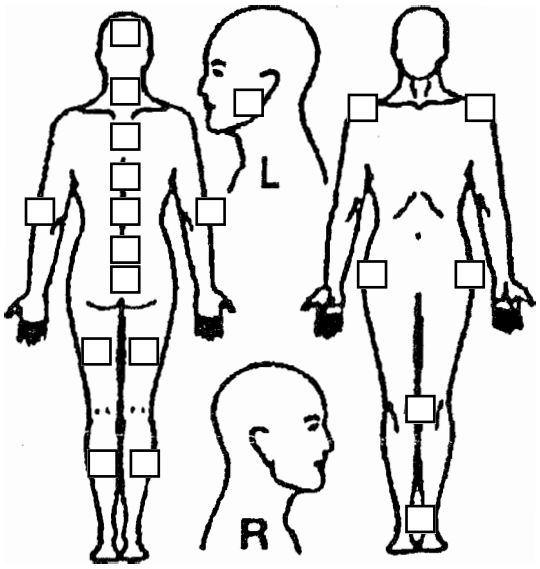
☐ Headache	☐ Eyes light sensitive	☐ Fainting	☐ Numbness in toes
☐ Low back pain	☐ Irritability	☐ Loss of balance	☐ Cold feet
☐ Chest pain	☐ Pain down the leg(s)	☐ Neck pain/ Stiffness	☐ Pain behind eyes
☐ Sleeping problems	☐ Loss of smell	☐ Fatigue	☐ Depression
☐ Tension	☐ Diarrhea	☐ Nervousness	☐ Facial Pain
☐ Mid back pain	☐ Dizziness	☐ Numbness in fingers	☐ Loss of taste
☐ Shortness of breath	☐ Ringing/ buzzing	☐ Cold hands	☐ Constipation
☐ Cold sweats	☐ Clicking/ popping jaw	☐ Sore jaw	☐ Hand grip weakness

List any others: _____

31. Subjective Pain Drawing

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of pain that travels. Include all affected areas.

☐ NUMBNESS ☐ BURNING ☐ PINS & NEEDLES ☐ STABBING ☐ ACHE



I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered.

_____ _____

Patients Signature Date

33. Additional Physicians Notes

_____

_____

_____

_____

_____

_____

_____

_____

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Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name: _____ File #: _____ Date: ____/____/____

Directions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check the **ONE ITEM** in each section which most closely applies to you.

SECTION 1 - PAIN INTENSITY
- ◯ The pain comes and goes and is very mild.
- ◯ The pain is mild and does not vary much.
- ◯ The pain comes and goes and is moderate.
- ◯ The pain is moderate and does not vary much.
- ◯ The pain comes and goes and is very severe.
- ◯ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE (washing, dressing, etc.)
- ◯ I would not have to change my way of washing or dressing in order to avoid pain.
- ◯ I do not normally change my way of washing or dressing even though it causes some pain
- ◯ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ◯ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ◯ Because of the pain I am unable to do some washing and dressing without help.
- ◯ Because of the pain I am unable to do some washing and dressing without help.
- ◯ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - LIFTING
- ◯ I can lift heavy weights without extra pain
- ◯ I can lift heavy weights but it causes extra pain
- ◯ Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned (e.g. on a table)
- ◯ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ◯ I can lift only very light weights at the most.

SECTION 4 - WALKING
- ◯ I have no pain on walking.
- ◯ I have some pain on walking but it does not increase with distance.
- ◯ I cannot walk more than one mile without increasing pain.
- ◯ I cannot walk more than 1/2 mile without increasing pain.
- ◯ I cannot walk more than 1/4 mile without increasing pain.
- ◯ I cannot walk at all without increasing pain.

SECTION 5 - SITTING
- ◯ I can sit in any chair as long as I like.
- ◯ I can only sit in my favorite chair as long as I like.
- ◯ Pain prevents me from sitting for more than one hour.
- ◯ Pain prevents me from sitting more than 30 minutes.
- ◯ Pain prevents me from sitting for more than 10 minutes.
- ◯ I avoid sitting because it increases pain straight away.

SECTION 6 - STANDING
- ◯ I can stand as long as I want without extra pain
- ◯ I have some pain on standing but it does not increase with time.
- ◯ I cannot stand for longer than one hour without increasing pain.
- ◯ I cannot stand for longer than 1/2 hour without increasing pain.
- ◯ I cannot stand for longer than 10 minutes without Increasing pain.
- ◯ I avoid standing because it increases the pain straight away.

SECTION 7 - SLEEPING
- ◯ I have no trouble sleeping.
- ◯ My sleep is slightly distrubed (less than 1 hr. sleepless).
- ◯ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ◯ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ◯ My sleep is greztly disturbed (3-5 hrs. sleepless).
- ◯ My sleep is completely disturbed (5 hrs. or more sleepless).

SECTION 8 - SOCIAL LIFE
- ◯ My social life is normal and gives me no pain.
- ◯ My social life is normal but increases the degree of pain.
- ◯ Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc.)
- ◯ Pain has restricted my social life and I do not go out very often.
- ◯ Pain has restricted my social life to my home.
- ◯ I have hardly any social life because of the pain.

SECTION 9 - TRAVELING
- ◯ I get no pain while traveling.
- ◯ I get some pain while travelling but none of my usual forms of travel make it any worse.
- ◯ I get extra pain while travelling but it does not compel me to seek alternative forms of travel.
- ◯ I get extra pain while travelling which compels me to seek alternative forms of travel.
- ◯ Pain restricts all forms of travel.
- ◯ Pain prevents all forms of travel except that done lying down.

SECTION 10 - CHANGING DEGREE OF PAIN
- ◯ My pain is radidly getting better.
- ◯ My pain fluctuates but overall is definitely getting better.
- ◯ My pain seems to be getting better but Improvement is slow at present.
- ◯ My pain is neither getting better nor worse.
- ◯ My pain is gradually worsening.
- ◯ My pain is radidly worsening.

Pain Severity Scale:

Rate the severity of your pain by checking one box on the following scale

No Pain | 0 ◯ | 1 ◯ | 2 ◯ | 3 ◯ | 4 ◯ | 5 ◯ | 6 ◯ | 7 ◯ | 8 ◯ | 9 ◯ | 10 ◯ | *Excruciating Pain*

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Neck Pain and Disability Index (Vernon-Mior)

Patient Name: _____ File #: _____ Date: ____/____/____

Directions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check the **ONE ITEM** in each section which most closely applies to you.

SECTION 1 - PAIN INTENSITY
- ◯ I have no pain at the moment.
- ◯ The pain is very mild at the moment.
- ◯ The pain is moderate at the moment.
- ◯ The pain is fairly severe at the moment.
- ◯ The pain is very severe at the moment.
- ◯ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE (washing, dressing, etc.)
- ◯ I can look after myself normally without causing extra pain.
- ◯ I can look after myself normally but it causes extra pain.
- ◯ It is painful to look after myself and I am slow and careful.
- ◯ I need some help but manage most of my personal care.
- ◯ I need help every day in most aspects of self care.
- ◯ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - LIFTING
- ◯ I can lift heavy weights without extra pain
- ◯ I can lift heavy weights but it causes extra pain
- ◯ Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned (e.g. on a table)
- ◯ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ◯ I can lift only very light weights.
- ◯ I cannot lift or carry anything at all.

SECTION 4 - READING
- ◯ I can read as much as I want to with no pain in my neck.
- ◯ I can read as much as I want to with slight pain in my neck.
- ◯ I can read as much as I want with moderate pain in my neck.
- ◯ I can't read as much as I want because of moderate pain in my neck.
- ◯ I can hardly read at all because of severe pain in my neck.
- ◯ I cannot read at all.

SECTION 5 - HEADACHES
- ◯ I have no headaches at all.
- ◯ I have slight headaches which come infrequently.
- ◯ I have moderate headaches which come frequently.
- ◯ I have severe headaches which come frequently.
- ◯ I have headaches almost all the time.

SECTION 6 - CONCENTRATION
- ◯ I can concentrate fully when I want to with no difficulty.
- ◯ I can concentrate fully when I want to with slight difficulty.
- ◯ I have a fair degree of difficulty in concentrating when I want to.
- ◯ I have a lot of difficulty in concentrating when I want to.
- ◯ I have a great deal of difficulty In concentrating when I want to.
- ◯ I cannot concentrate at all.

SECTION 7 - WORK
- ◯ I can do as much work as I want to.
- ◯ I can only do my usual work, but no more.
- ◯ I can do most of my usual work, but no more.
- ◯ I cannot do my usual work.
- ◯ I can hardly do any work at all.
- ◯ I can't do any work at all.

SECTION 8 - DRIVING
- ◯ I can drive my car without any neck pain.
- ◯ I can drive my car as long as I want with slight pain in my neck.
- ◯ I can drive my car as long as I want with moderate pain in my neck.
- ◯ I can't drive my car as long as I want because of moderate pain in my neck.
- ◯ I can hardly drive at all because of severe pain in my neck.
- ◯ I can't drive my car at all.

SECTION 9 - SLEEPING
- ◯ I have no trouble sleeping.
- ◯ My sleep is slightly disturbed (less than 1 hour sleepless).
- ◯ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ◯ My sleep is moderately disturbed (2-3 hrs. sleepless)
- ◯ My sleep is greatly disturbed (3-5 hrs. sleepless)
- ◯ My sleep is completely disturbed (5-7 hrs. sleepless)

SECTION 10 - RECREATION
- ◯ I am able to engage in all my recreation activities with no neck pain at all.
- ◯ I am able to engage in all my recreation activities, with some pain in my neck.
- ◯ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ◯ I am able to engage In a few of my usual recreation activities because of pain in my neck.
- ◯ I can hardly do any recreation activities because of pain in my neck.
- ◯ I can't do any recreation activities at all.

Pain Severity Scale:

Rate the severity of your pain by checking one box on the following scale:

No Pain | 0 ◯ | 1 ◯ | 2 ◯ | 3 ◯ | 4 ◯ | 5 ◯ | 6 ◯ | 7 ◯ | 8 ◯ | 9 ◯ | 10 ◯ *Excruciating Pain*

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AS OF APRIL 1, 2019, we are able to bill ICBC directly for Chiropractic treatment, Acupuncture treatment and Athletic therapy treatment. We need this form filled out if you would like us to bill ICBC directly and have been pre-approved for us to do so.

Patient Name: _____

ICBC Claim #: _____

Accident date(s): _____

Adjuster's name: _____

Adjuster's Phone:

_____

Adjusters email:_____

If you have a lawyer please fill this out even if we already have your lawyers information

Law Firm: _____

Lawyer's name: _____

Legal Assistants name: _____

_____

Legal Assistants email:

PLEASE NOTE:

~If your accident was BEFORE April 1, 2019: We need a copy of an email from your adjuster or lawyers office stating your pre-approval for treatments and the most recent doctors note you have referring you for treatment. If ICBC refuses payment even after pre-approval, it is up to you or your lawyer to dispute this, not us unfortunately. You will be responsible to pay out of pocket for any costs ICBC refuses to pay.

~If your accident was AFTER April 1, 2019: We need this form filled out and handed in before we can start direct billing ICBC. As well we also recommend a Medical doctors note referring you for treatment as a back-up just in case. Automatically you are supposed to be covered for 25 Chiropractic treatments, 12 acupuncture treatments and 12 athletic therapy treatments if your accident was after April 1, 2019 with an end date of treatment being 12 weeks after your accident. We are able to request more treatments beyond 12 weeks if need be but cannot guarantee it will be approved. In that case you will be responsible for any costs not paid. If ICBC refuses payment even after pre-approval, it is up to you or your lawyer to dispute this, not us unfortunately. You will be responsible to pay out of pocket for any costs ICBC refuses to pay.

BY SIGNING BELOW YOU ARE AUTHORIZING US TO USE THIS INFORMATION TO BILL ICBC DIRECTLY AND YOU UNDERSTAND EVERYTHING YOU HAVE READ.

SIGN: _____ DATE: _____