AUTOMOBILE ACCIDENT INJURY FORM

Name: _____ Date: _____

Date of accident: _____ Time: _____ a.m./p.m.

Location: _____

Were you the:

- ☐ Driver
- ☐ Passenger in the front seat
- ☐ Passenger in the back seat
- ☐ Pedestrian

Were you struck from:

- ☐ Behind
- ☐ Right side
- ☐ Left side
- ☐ Front

How fast was the car moving? _____ (km/hr)

How many cars were involved? _____

Did you:

- ☐ Hit another car/object
- ☐ Get hit by another car/ object
- ☐ Undetermined

Were you wearing your seatbelt? _____

Were you prepared for the collision? _____

Did your body hit anything in the car (steering wheel, dash, etc.?) Please explain:

_____

_____

Did the force of the accident throw anything around in the car? Please explain:

_____

Did you lose consciousness? _____

Were you taken to the hospital? _____

Name of hospital: _____

Were you examined? _____ Were you x-rayed? _____ Were you treated? _____

What treatment did you receive? _____

List the extent of your injuries as you know them:_____

_____

Check any symptoms you have noticed since the accident:

- ☐ headache
- ☐ stiff neck
- ☐ dizziness
- ☐ faintness
- ☐ stomach upset
- ☐ face flushed
- ☐ nervousness
- ☐ irritability
- ☐ cold sweats
- ☐ light bothers eyes
- ☐ head seems too heavy
- ☐ pins & needles in arms
- ☐ pins & needles in legs
- ☐ sleep problems
- ☐ numbness in fingers
- ☐ numbness in toes
- ☐ shortness of breath
- ☐ other: _____

How soon did the symptoms start? _____

Have you lost any time from work? _____ Dates: _____
If you are a care-giver, have you lost time from care-giving? Yes No N/A (circle one)

Prior to the accident, did you have any disease, condition or injury that could affect your response to treatment for the injuries related to your accident? Yes Unknown No (circle one)
If yes, please explain: _____
_____

If yes to above, did you undergo investigation or receive treatment for this disease, condition or injury in the past year? Yes No (circle one)
If yes, please explain: _____
_____

Does your impairment(s) from the MVA injuries affect your ability to carry out: (please circle answer)

Your tasks of employment: Yes Unknown No N/A

Your activities of normal life: Yes Unknown No

If yes to either of the above, briefly describe the activities limited by the impairment and their impacts on your ability to function:

_____
_____
_____

If you are unable to carry out pre-accident employment activity, is your employer able to provide suitable modified employment? Yes Unknown No (circle one)

If no, please explain: _____
_____

List the name(s) of any other healthcare provider(s) you have seen for this injury:

_____

Is there any concurrent treatment at this time provided by this or another facility? Yes No (circle one)

Is yes, please explain: _____
_____

NECK FUNCTION INDEX

Please mark the ONE BOX that most closely describes your complaint.

Current Pain Intensity

- ☐ I have no pain
- ☐ The pain is very mild
- ☐ The pain is moderate
- ☐ The pain is fairly severe
- ☐ The pain is very severe
- ☐ The pain is the worst imaginable

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 don't get dressed. I wash with difficulty & stay in bed

Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if the are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

Reading

- ☐ I can read as much as I want to with no neck pain
- ☐ 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 neck pain
- ☐ I can't read as much as I want because of moderate neck pain
- ☐ I can hardly read at all because of severe neck pain
- ☐ I can't read at all because of severe neck pain

Headaches

- ☐ I have no headaches at all
- ☐ I have slight headaches which come infrequently
- ☐ I have moderate 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

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 some difficulty concentrating when I want to
- ☐ I have a moderate degree of difficulty concentrating when I want to
- ☐ I have a great deal of difficulty concentrating when I want to
- ☐ I cannot concentrate at all

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

Driving

- ☐ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want to with slight neck pain
- ☐ I can drive my car as long as I want with moderate neck pain
- ☐ I cannot drive my care as long as I want because of moderate neck pain
- ☐ I can hardly drive at all because of severe neck pain
- ☐ I cannot drive at all because of severe neck pain

Sleeping

- ☐ I have no trouble sleeping
- ☐ I get pain in bed but it does not prevent me from sleeping
- ☐ Due to pain, my normal sleep is reduced by less than 1/4
- ☐ Due to pain, my normal sleep is reduced by less than 1/2
- ☐ Due to pain, my normal sleep is reduced by less than 3/4
- ☐ Pain prevents me from sleeping at all

Recreation

- ☐ I am able to engage in all my recreational activities with no neck pain at all
- ☐ I am able to engage in all my recreational activities with some neck pain
- ☐ I am able to engage in most, but not all of my usual recreational activities because of neck pain
- ☐ I am able to engage in a few of my usual recreational activities because of neck pain
- ☐ I can hardly do any recreational activities because of neck pain
- ☐ I can't do any recreational activities at all

LOW BACK FUNCTION INDEX

Please mark the ONE BOX that most closely describes your complaint.

Current Pain Intensity

- ☐ I have no pain
- ☐ The pain is very mild
- ☐ The pain is moderate
- ☐ The pain is fairly severe
- ☐ The pain is very severe
- ☐ The pain is the worst imaginable

Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes some 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 & stay in bed

Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if the are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

Walking

- ☐ I have no pain when I walk
- ☐ I have some pain when I walk but it does not increase with distance
- ☐ I cannot walk more than one mile without increased pain
- ☐ I cannot walk more than 1/2 mile without increased pain
- ☐ I cannot walk more than 1/4 mile without increased pain
- ☐ I cannot walk at all without increased pain

Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can sit only in my favourite chair as long as I like
- ☐ Pain prevents me from sitting for more than 1 hour
- ☐ Pain prevents me from sitting for more than 1/2 hour
- ☐ Pain prevents me from sitting for more than 10 minutes
- ☐ I avoid sitting because it increases pain immediately

Standing

- ☐ I can stand as long as I want without pain
- ☐ I have some pain when I stand but it does not increase with time
- ☐ I cannot stand more than one hour without increased pain
- ☐ I cannot stand more than 1/2 hour without increased pain
- ☐ I cannot stand more than 1/4 hour without increased pain
- ☐ I avoid standing because it increases the pain immediately

Sleeping

- ☐ I have no trouble sleeping
- ☐ I get pain in bed but it does not prevent me from sleeping
- ☐ Due to pain, my normal sleep is reduced by less than 1/4
- ☐ Due to pain, my normal sleep is reduced by less than 1/2
- ☐ Due to pain, my normal sleep is reduced by less than 3/4
- ☐ Pain prevents me from sleeping at all

Recreation

- ☐ I am able to engage in all my recreational activities with no back pain at all
- ☐ I am able to engage in all my recreational activities with some back pain
- ☐ I am able to engage in most, but not all of my usual recreational activities because of back pain
- ☐ I am able to engage in a few of my usual recreational activities because of back pain
- ☐ I can hardly do any recreational activities because of back pain
- ☐ I can't do any recreational activities at all

Driving

- ☐ I can drive my car without any back pain
- ☐ I can drive my car as long as I want to with slight back pain
- ☐ I can drive my car as long as I want with moderate back pain
- ☐ I cannot drive my care as long as I want because of moderate back pain
- ☐ I can hardly drive at all because of severe back pain
- ☐ I cannot drive at all because of severe back pain

Changing Degree of Pain

- ☐ My pain is rapidly getting better
- ☐ My pain fluctuates but overall is getting better
- ☐ My pain seems to be getting better slowly
- ☐ My pain is neither getting better or worse
- ☐ My pain is gradually worsening
- ☐ My pain is rapidly worsening

IMPORTANT: By providing this information you are consenting to the release of your health information and billing schedule to your extended health care and motor vehicle insurance companies. Please initial to indicate your consent: _____

Auto Insurance Information:

Insurance Company Name: _____

City of Branch Office: _____

Adjuster Last Name: _____ First Name: _____

Phone #: _____ Extension: _____

Fax #:: _____

Policy Holder Last Name: _____ First Name: _____

Policy # _____ Claim # _____

Extended Health Insurance Information

Is there other insurance coverage that is potentially available to cover/partially cover these goods and services? Yes No (circle one)

If yes, please provide:
Other Insurer Name: _____

Plan or Policy Number: _____

Name of Member: _____

Other Insurers' Identifier: _____

Is there a second or additional option for insurance coverage that is potentially available to cover/partially cover these goods and services? Yes No (circle one)

If yes, please provide:
Other Insurer Name: _____

Plan or Policy Number: _____

Name of Member: _____

Other Insurers' Identifier: _____

Amount of Extended Health Coverage:

Chiropractic:

	Amount/Percent Covered per Treatment	Total Dollar Amount Coverage	Amount Remaining	Reset Date
Benefit Plan 1				
Benefit Plan 2				

Massage:

	Amount/Percent Covered per Treatment	Total Dollar Amount Coverage	Amount Remaining	Reset Date
Benefit Plan 1				
Benefit Plan 2				

Other: (please specify ex. Acupuncture)

	Amount/Percent Covered per Treatment	Total Dollar Amount Coverage	Amount Remaining	Reset Date
Benefit Plan 1				
Benefit Plan 2				

Flex plan – to cover all practitioners:

	Amount/Percent Covered per Treatment	Total Dollar Amount Coverage	Amount Remaining	Reset Date
Benefit Plan 1				
Benefit Plan 2				

If needed, please provide further explanation about your flex plan:

_____

_____