

# AUTOMOBILE ACCIDENT INJURY FORM

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

Date of accident: \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m.

Location: \_\_\_\_\_

Were you the:

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

Were you struck from:

- Behind  Left side  
 Right 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:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> headache      | <input type="checkbox"/> irritability           | <input type="checkbox"/> numbness in fingers |
| <input type="checkbox"/> stiff neck    | <input type="checkbox"/> cold sweats            | <input type="checkbox"/> numbness in toes    |
| <input type="checkbox"/> dizziness     | <input type="checkbox"/> light bothers eyes     | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> faintness     | <input type="checkbox"/> head seems too heavy   | <input type="checkbox"/> other: _____        |
| <input type="checkbox"/> stomach upset | <input type="checkbox"/> pins & needles in arms |  |
| <input type="checkbox"/> face flushed  | <input type="checkbox"/> pins & needles in legs |  |
| <input type="checkbox"/> nervousness   | <input type="checkbox"/> sleep problems         |  |

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 they 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 car 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 they 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 car 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:

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