MOTOR VEHICLE ACCIDENT HISTORY

Last Name:_____ First name: _____

Birthdate:_____ Name I prefer to go by:_____

Address: _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Today's date: _____ Date of Accident: _____

ICBC Claim #: _____ Care Card #: _____

Adjuster's Name: _____Direct Phone Line # _____ Fax # _____

Lawyer's Name: _____

Mailing Address: _____

Lawyer's Phone #: _____ Fax # _____

Accident Scene

Please describe the accident that you had, to the best of your ability

_____
_____
_____
_____
_____
_____

Please compile a complete list including all of your symptoms/ complaints

_____
_____
_____
_____
_____
_____
_____
_____

List of Symptoms

1. How did you feel right after the impact / injury?
   _____
   _____
   _____
2. How did you feel that day / night?
   _____
   _____
   _____
3. How did you feel over the next couple of days?
   _____
   _____
   _____

Patient Name:_____ Date:_____

4. How do you feel today?
   _____
   _____
   _____

5. Your primary concern and expectations on recovery are?
   _____
   _____
   _____

Injury Mechanics

Please give good detail on **your position in the vehicle**:

Before impact/ injury (ie. Looking in rearview mirror, hand on steering wheel):
_____
_____

During impact / injury:
_____
_____

After impact / injury:
_____
_____

Motor Vehicle Accident Information

Please circle the applicable response:

In this MVA were you the: the driver the passenger a pedestrian

Was this collision: mild moderate severe

In this collision were you struck from : front back right side left side

Were you: stopped traveling km/hr _____

Did your vehicle contact anything: _____
_____

Estimated damage to vehicle: _____

Type of seat belt : shoulder/ lap lap

Was seat belt on at time of impact ? Yes No

Did you require hospitalization? Yes No (If yes, describe ie. X-rays, stitches, etc.)
_____
_____
_____

Patient Name:_____ Date:_____

Please mark areas of injury or discomfort. Please indicate degree of pain on the pain scale below.

Numbness	Pins & Needles	Burning	Aching	Stabbing
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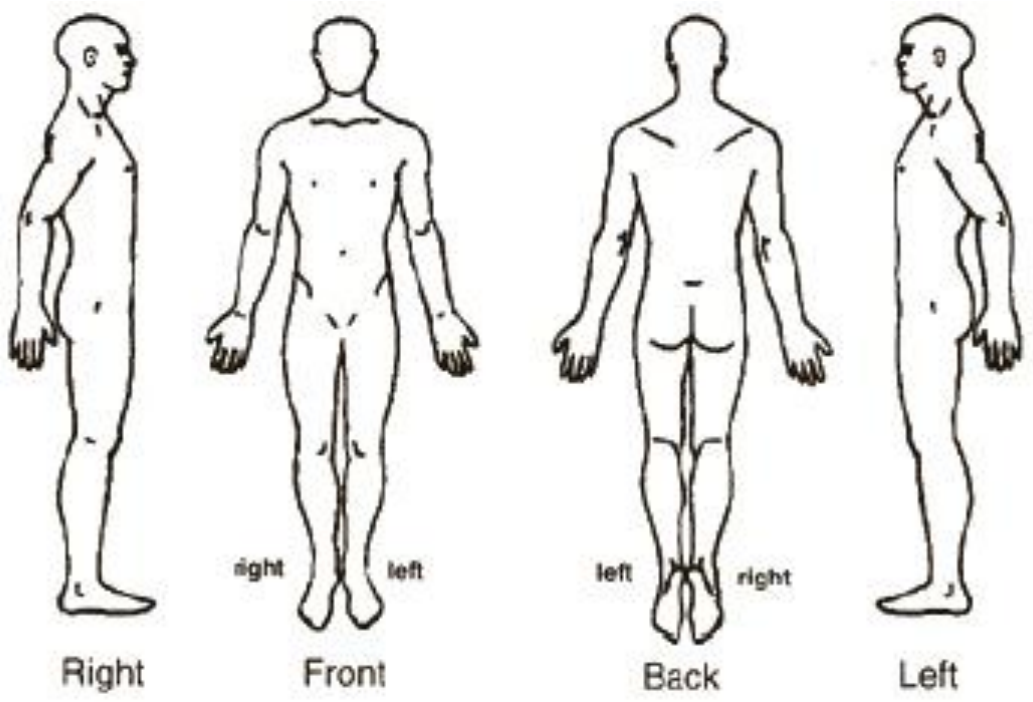

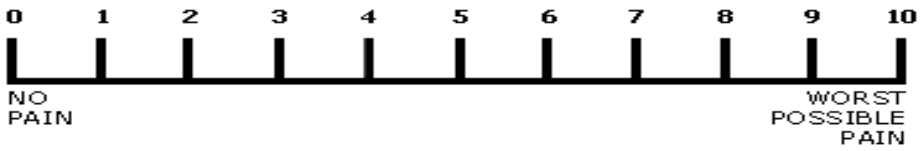

Please list medications that you take, the reason, and if it is taken on a regular basis:

Medication Name	Reason	Regular Basis
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

Please list any minerals or supplements that you take and if they are taken on a regular basis:

Supplement Name	Regular Basis	Supplement Name	Regular Basis
_____	☐ Yes ☐ No	_____	☐ Yes ☐ No
_____	☐ Yes ☐ No	_____	☐ Yes ☐ No
_____	☐ Yes ☐ No	_____	☐ Yes ☐ No

I affirm that all information on this form are true and correct to the best of my knowledge.
I understand that I am responsible for all visit charges at this office not covered by ICBC or my lawyer.

I understand there is a 24 hour cancellation policy and that I may be charged for last minute cancellations.

Patient Signature:_____ **Date:**_____