Total Body Health

Motor Vehicle Accident Examination Form

Legal First Name: ____________________ Legal Last Name:____________________

Date of birth: ________________M ___F___ Martial Status ______ No.of children___

Service Card Health #__________________ ICBC Claim# ____________________

Address: ______________________________________ City: _________________

Province: ______ Postal Code: ________ Phone #: ________________________

Age: ____ Birth Date: ___/___/___ Height: _____ Weight: ______ Sex: (M□,F□)

Occupation: _________________ Company Name: __________________________

Work Address: ____________________________ City: ____________ Prov: ____

Postal Code: ___________ Phone #: _____________________

Referred By: _______________________ Current Physician: ___________________

____

Date of Accident: (M/D/Y) ___/___/___ Time: ____________am / pm

Location: _________________________

Do you have a copy of the police report? Yes □ No □

Were you taken to the hospital? Yes □ No □ If yes, which hospital ______________

How did you get to the hospital? ____

While at the hospital, what test, x-rays, etc., were done? _________________________

Were you given any special instructions? ___________________________________

List any medications that were given to you following the accident. ________________

____

Have you been seen by anyone else? Yes □ No □ Names:_______________

____

Road conditions at time of accident: Wet □, Dry □, Ice □, Snow Covered □,

Other □ ________________________________

Type of road surface: ______________________ Type of vehicle you were in: (Car,

Truck, Bike, etc.)__________________ Year: _______ Make: __________________

Model: ____________________

If there was no other vehicle, what did your vehicle hit? ___________________________

Where were you seated in the vehicle? __________________________

If you were on a motorcycle or bike were you the driver or passenger?________________

If you were on a motorcycle or bike, were you wearing a helmet? Yes ☐ No ☐

If yes, Make: ____________ Model: ____________ Number of years old: ____

Were you wearing a seatbelt? Yes ☐ No ☐

If yes, was it adjusted correctly? Yes ☐ No ☐

Did the seatbelt hold during the impact Yes ☐ No ☐

Was there a headrest on your seat? Yes ☐ No ☐

Was the headrest adjusted properly for head or neck? ________________

Did your vehicle have air bags? Yes ☐ No ☐ If yes, which air bags deployed at the time of impact? Driver's side air bag ☐ Passenger side air bag ☐ Side impact bags ☐

Was there any injuries from the air bags? Yes ☐ No ☐

If yes, explain. ____

At the time of impact, how were you seated in the vehicle (straight ahead, turned, etc.)?

____

What was the position of your head at impact (turned right/left, straight ahead etc.)?

____

If you were the driver, did you have time to brace yourself? Yes ☐ No ☐

If yes, what on? ____

If you were a passenger, did you have time to brace yourself? Yes ☐ No ☐

If yes, what on? ____

Was your foot on the brake? Yes ☐ No ☐ Was your car stopped or rolling?___________

If you were moving, what was your estimated speed? ___________Km/h

Was your car slowing down, gaining speed, at a steady rate, etc? ____________________

If you were stopped, estimate the speed of the other vehicle at impact. ___________Km/h

Did you lose consciousness (blackout) upon impact? Yes ☐ No ☐

If yes, how long were you unconscious? ___________________________________

If you were not "knocked out," were you aware of what was going on around you?

Yes ☐ No ☐ Explain:__________________________

At the point of impact, did you see stars, bright white lights, or did you feel a blinding or explosive sensation to your head? Yes ☐ No ☐

Was one or both shoes knocked off, due to the impact? Yes ☐ No ☐ ________________

Please describe to the best of your ability what happened during the accident. _________

____

____

____

Which of the following parts of the vehicle broke during the accident:

Windshield ☐	Right/Left Side Window ☐	Steering Wheel ☐
Your Seatbelt ☐	Your Seat Rail ☐	Other: __________________

Were you able to get out of your vehicle by yourself? Yes ☐ No ☐

If no, explain. ____

Describe where your vehicle hit or was struck. ___________________________

____

In the space below, complete a sketch of accident scene.

What areas of your body were bruised? _____________________________________

What part of the vehicle did the following body parts hit?

Head ____

Chest/Back ____

Right/Left Shoulder ____

Right/Left Arm, Elbow, Wrist, Hand ______________________________________

Right/Left Knee ____

Right/Left Hip ____

Right/Left Ankle, Foot ____

Other ____

Did you have any broken bones? Yes □ No □ Explain ____________________

Did any objects in the car hit you? Yes □ No □ Explain ____________________

What position were you in following the impact? ________________________

Were you able to walk unaided? Yes □ No □

Describe any pain or discomfort immediately following the accident. ____________

____

Describe any pain or discomfort later that **same day**. _____________________

____

Describe any pain or discomfort the **following day**. _____________________

____

What has been the progression of the symptoms, from the time of the accident until now? (Example: what aches, pains, and limitations do you have now that you did not have prior to the accident?) ____

What symptoms have improved since the accident? ____________________

____

Do you feel you have a good recall of the accident and the time period immediately following the accident? Yes □ No □

Have you been in any previous auto accidents? List the year and briefly explain what happened and to what extent you were injured in each accident: ______________

____

____

Are there any residuals, pain or discomfort from a previous accident that were bothering you before, or that have worsened since this accident? ____________________

____

____

Have you missed any work because of this accident? Yes □ No □

If yes give details: ____________________________________

Are you able to perform you regular duties without limitations? Yes □ No □

If no, are you on light duty, another job classification, etc.? ___________________

____

Will this accident affect your ability to maintain your current job? Yes □ No □

Do you have a lawyer handling this case for you? Yes □ No □

If yes, name of lawyer: ____

Name of Law firm: ____

Address: ________________________________ City: _________ Province: _____

Phone number: _______________________________

Patient Signature: ______________________________ Date: _______________

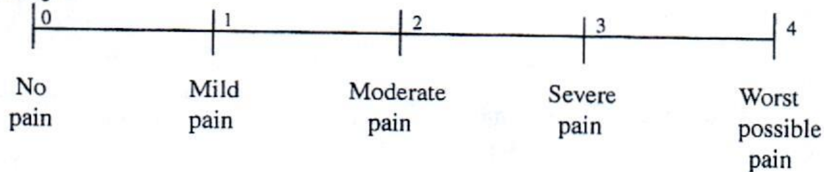
Parent/guardian signature: __________________________Date:_____________

Functional Rating Index

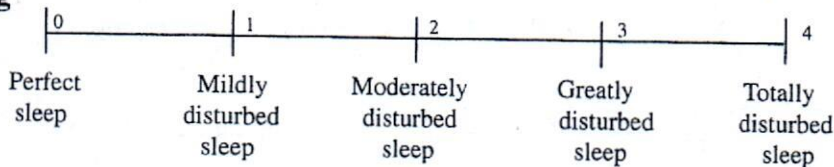
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

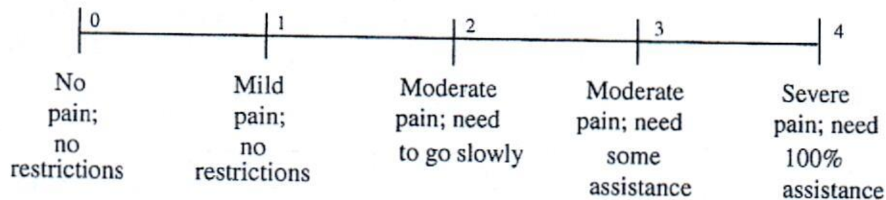
1. Pain Intensity



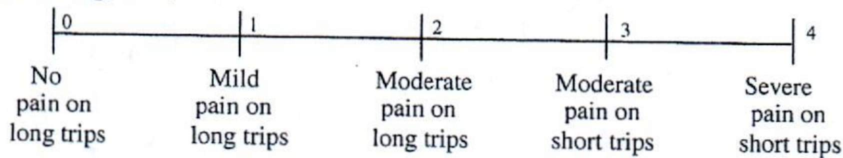
2. Sleeping



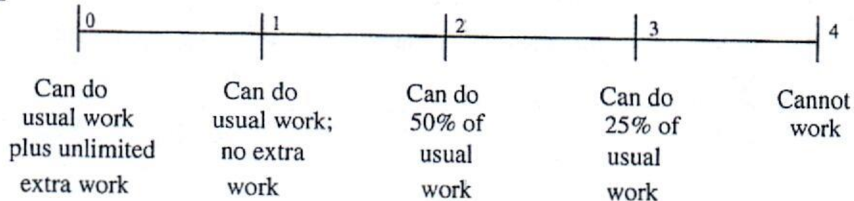
3. Personal Care (washing, dressing, etc.)



4. Travel (driving, etc.)

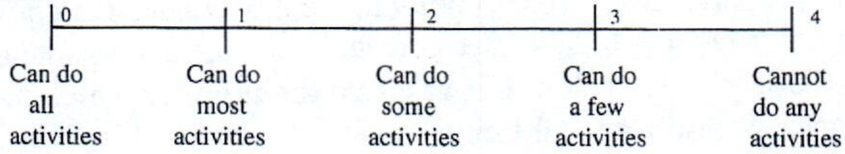


5. Work

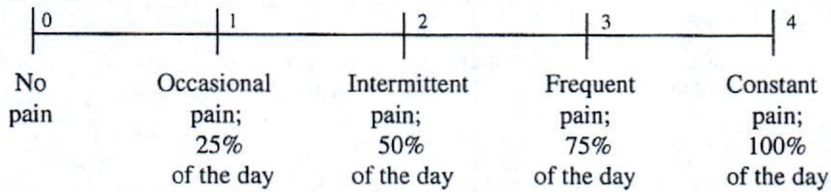


Please Turn Over

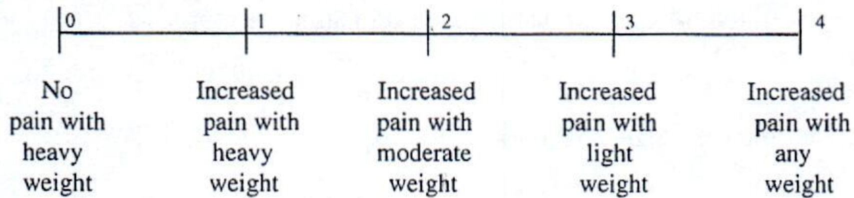
6. Recreation



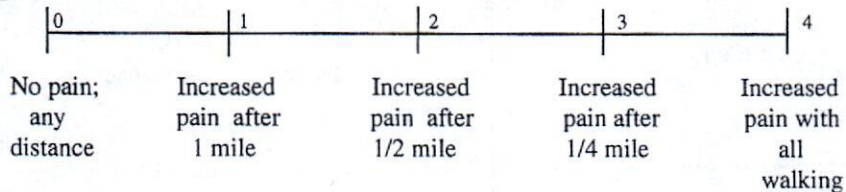
7. Frequency of pain



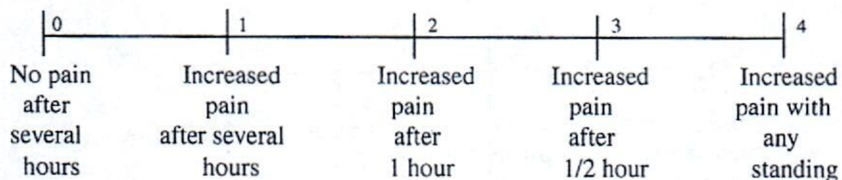
8. Lifting



9. Walking



10. Standing



______________________________ ______________

Patient's Signature **Date**

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NECK PAIN AND DISABILITY INDEX (Vernon-Mior)

Patient Name: ______________________________ File# __________ Date ____________

PLEASE READ INSTRUCTIONS:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

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 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.

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 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 alot 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 with 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 hours sleepless).
- ❑ My sleep is moderately disturbed (2-3 hours sleepless).
- ❑ My sleep is greatly disturbed (3-5 hours sleepless).
- ❑ My sleep is completely disturbed (5-7 hours 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 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 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

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (Revised Oswestry)

Patient Name: ______________________________ File# ____________ Date ____________

PLEASE READ INSTRUCTIONS:

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

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 severe.
- ❑ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE

- ❑ 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 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 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 weights off the floor.
- ❑ Pain prevents me from lifting heavy weights 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 only lift very light weights at the most.

SECTION 4 - WALKING

- ❑ I have not pain on walking.
- ❑ I have some pain on walking but it does not increase with distance.
- ❑ I cannot walk more than one km. without increasing pain.
- ❑ I cannot walk more than ½ km. without increasing pain.
- ❑ I cannot walk more than ¼ km. 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 favourite chair as long as I like.
- ❑ Pain prevents me from sitting more than one hour.
- ❑ Pain prevents me from sitting more than half hour.
- ❑ Pain prevents me from sitting 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 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 ½ 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 get no pain in bed.
- ❑ I get pain in bed but it does not prevent me from sleeping well.
- ❑ Because of pain my normal night's sleep is reduced by less than ¼.
- ❑ Because of pain my normal night's sleep is reduced by less than ½.
- ❑ Because of pain my normal night's sleep is reduced by less than ¾.
- ❑ Pain prevents me from sleeping at all.

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 (e.g. 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 - TRAVELLING

- ❑ I get no pain whilst travelling.
- ❑ I get some pain whilst travelling but none of my usual forms of travel make it any worse.
- ❑ I get extra pain whilst travelling but it does not compel me to seek alternative forms of travel.
- ❑ I get extra pain whilst 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 rapidly 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 rapidly 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

CONSENT to RELEASE MEDICAL INFORMATION to ICBC

Based on Section 28 or Section 28.1 of the *Insurance (Vehicle) Act,* I consent to share information related to the history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC.

I understand that my consent may be amended or revoked in whole or in part at any time by providing written notice to the clinic or practitioner.

Name ____________________ Signature ____________________ Date ____________________

Personal information on this form is being collected under Section 26 of the *Freedom of Information and Protection of Privacy Act (BC)* and Section 28 or 28.1 of the *Insurance (Vehicle) Act (BC)* for the purpose of obtaining a health care report in order to investigate, manage or settle a claim. Questions about the collection of this information may be directed to the adjuster, or call 604-661-2800 or contact the Privacy & Freedom of Information (FOI) Department at 151 W Esplanade, North Vancouver, BC V7M 3H9.

If ICBC doesn't accept this claim, I understand that I am responsible for my account and fees for care at Total Body Health.

Name ____________________ Signature ____________________ Date ____________________

To be completed by parent or legal guardian if patient is younger than 19 years old:

I, the undersigned, represent that I am the ____________________ (parent or legal guardian) of ____________________ (the patient) named above, and as such I am fully authorized and entitled to enter into this treatment confirmation and consent, and hereby agree to all of the above, on behalf of the patient. I confirm that I am 19 years old or older, have read and understood the foregoing, and agree to be bound to it.

Signed at ____________________ B.C on the __________ day of __________ 20____.

In the presence of:

Parent or legal guardian signature ____________________ Parent or legal guardian Printed Name ____________________

Witness signature ____________________ Witness Printed Name ____________________