MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Name: _____ ICBC Claim Centre: _____

Date of Birth: _____ Adjuster Name: _____

CareCard #: _____ Adjuster Phone #: _____

Accident Date & Time: _____ Lawyer Y / N? If yes, please give contact info to front desk.

Please describe the accident in your own words: _____

_____

_____

_____

What was your position in the car?

❑ Driver: Were your hands on the steering wheel? ❑ Left ❑ Right ❑ Both

❑ Passenger: Were you sitting in ❑Front ❑Right Rear ❑ Left Rear

Did your vehicle strike another vehicle? ❑ Yes ❑ No

Was your vehicle struck by another vehicle? ❑ Yes ❑No

Angles of impact... First Collision: ❑ Front ❑ Back ❑ Left ❑ Right

If Second Collision: ❑ Front ❑ Back ❑ Left ❑ Right

Were you wearing a seat belt? ❑ Yes ❑No

Did you brace for impact? ❑ Yes ❑ No... ❑ I braced with my hands ❑ I braced with my feet

Which way were you facing at the time of impact? ❑ Straight ahead ❑ Left ❑ Right

Did your body strike anything in the vehicle at the time of impact? ❑ Yes ❑ No

If yes, please specify what part of your body struck what: ie... head, chest, chin, shoulder, right/left knee, etc.

❑ Steering Wheel_____ ❑ Dashboard _____

❑ Windshield _____ ❑ Roof _____

❑ Left Side Door _____ ❑ Right Side Door _____

❑ Left Side Window _____ ❑ Right Side Window _____

❑ Other _____

Did the seat back bend / break? ❑ Yes ❑ No

Immediately following the accident, how did you feel? ❑ Dizzy/dazed ❑disoriented ❑ nervous

❑ nauseous ❑ upset ❑ weak ❑ other _____

Were you knocked unconscious? ❑ Yes ❑ No

Did you go to the hospital? ❑ Yes ❑ No Were you admitted? ❑ Yes ❑ No If yes, for how long? _____

If you went to hospital, when? ❑ At time of accident ❑ Next day

How did you get to hospital? ❑ Ambulance ❑ Police Car ❑ Private Transportation

Name of Hospital: _____

Attended by Dr.: _____

What treatment was given? ❑ None ❑ Placed in a cervical collar ❑ x-rayed

❑ given stitches ❑bandaged ❑Given pain medication ❑given instructions regarding concussions

❑given instructions regarding sprains and strains ❑Physical Therapy

❑ instructed to call and Orthopaedic Surgeon ❑ instructed to call a private physician

❑ referred to this office for treatment ❑Other_____

Have you seen any other doctor as a result of this accident? ❑ Yes ❑ No

Doctor's name: _____ Phone #: _____

CHIEF Complaints or Symptoms: **Name:** _____ **Date:** _____

❑ **Neck pain** (select the areas of radiation)

❑ none

❑ left shoulder	❑ left arm	❑ left forearm	❑ left hand
❑ right shoulder	❑ right arm	❑ right forearm	❑ right hand

❑ Headache ❑ Migraine Headache ❑ Upper Back pain

Ringing in Ears:	❑ Yes ❑ No;	❑ Left	❑ Right	❑ Both Ears
Blurry Vision:	❑ Yes ❑ No;	❑ Left	❑ Right	❑ Both Eyes
Jaw Pain:	❑ Yes ❑ No;	❑ Left	❑ Right	❑ Both Sides
Wrist Pain:	❑ Yes ❑ No;	❑ Left	❑ Right	❑ Both Wrists

Are you experiencing any of the following?

❑ dizziness ❑ nervousness ❑ fatigue ❑ anxiety ❑ depression ❑ excessive irritability
❑ fear of driving in a car ❑ a loss of concentration ❑ jaw clenching ❑ night teeth grinding
❑ nightmares ❑ difficulty with sleeping at night

❑ **Low back pain** (select the areas of radiation)

❑ none ❑ buttocks

❑ left buttock	❑ left thigh	❑ left knee	❑ left foot
❑ right buttock	❑ right thigh	❑ right knee	❑ right foot

Hip Pain:	❑ Yes ❑ No;	❑ Left	❑ Right	❑ Both Hips
Knee Pain:	❑ Yes ❑ No;	❑ Left	❑ Right	❑ Both Knees
Foot/Ankle Pain	❑ Yes ❑ No;	❑ Left	❑ Right	❑ Both Feet/Ankles

Are you experiencing any NUMBNESS in any of the following areas?

❑ left hand	❑ left upper arm	❑ right hand	❑ right upper arm
❑ left foot	❑ left leg	❑ right foot	❑ right leg

Additional Symtoms/Complaints: _____

_____

_____

_____

_____

_____

_____

_____

Have you lost any time from work due to your injuries? ❑ Yes ❑ No

If yes, please give dates: _____

Type of employment: _____

Patient Signature: _____ **Date:** _____