Name: _____

Date: _____

Email Address: _____

AHC #: _____

MVA Patient Health Record

Relax • Breathe • Smile ☺

We are happy you are here!

As a full spectrum Wellness Centre, we focus on your ability to be healthy. Our goals are firstly, to address the issues which brought you into our office, and secondly to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis, you experience physical, chemical and emotional stress which can accumulate and result in a serious loss of health and compromised function. Most times the effects are gradual, not even detectable until they become serious. Answering the following questions will provide us with a profile of the specific stressors you face and have dealt with over your lifetime, allowing us to better assess the challenges to your health.

BEACON HILL
CHIROPRACTIC AND MASSAGE
~NORTHWEST~

Patient Name _____
Date_____

PERSONAL INJURY – PATIENT DATA FORM

1. Date of Accident: _____
2. Time: _____(AM/PM)
3. Driver of vehicle: _____
4. Where were you seated? _____
5. Who owns the car? _____
6. Year/Model of car: _____
7. What was the approximate damage done to you vehicle? $_____
8. Visibility at the time of accident: poor/fair/good/other (please describe):

   _____
9. Road Conditions at the time of the accident: icy/rainy & wet/clear/other (please describe):

   _____
10. Where was your car struck? right/left/rear/front/side/other (please describe):

    _____
11. Type of accident:
    ( ) head-on collision ( ) broad-side collision
    ( ) rear-end collision ( ) front impact, rear-ended car in front
    ( ) non-collision (please describe):

    _____
12. Describe in your own words what happened to you on impact:

    _____
13. Did you see the accident coming? Yes/No
14. If yes, did you brace for the accident? Yes/No
15. Were seat belts worn? Yes/No
16. Were shoulder harnesses worn? Yes/No
17. Does your car have headrests? Yes/No
18. If yes, what was the position of those headrests compared to your head before the accident?
    ( ) top of headrest even with ***bottom*** of head.
    ( ) top of headrest even with ***top*** of head.
    ( ) top of headrest even with the ***middle of neck***.
19. Was the car braking? Yes/No
20. Was your car moving at the time of the accident? Yes/No
21. If yes, how fast would you estimate you were going? _____ (km/hour)
22. How fast was the other vehicle traveling? _____ (km/hour)
23. Head/Body position at the time of impact:
    ( ) head turned to the left/right ( ) body straight in the sitting position
    ( ) head looking back ( ) body rotated left/right
    ( ) head straight forward ( ) other: _____

24. At the time of the accident, recall what parts of your ***head*** or ***body*** hit what parts on the inside of your car:

_____

25. As a result of the accident were you:
    ( ) rendered unconscious ( ) dazed, circumstances vague
    ( ) other: _____
26. Could you move all parts of your body? Yes/No
27. If no, what parts and why?

_____

28. Were you able to get out of the car and walk unaided? Yes/No
29. If no, why not?

_____

30. What bleeding cuts did you get from the accident?_____
31. What bruises did you get from the accident?_____
32. Please describe how you felt: (Be specific)
    a) ***Immediately after the accident:***

_____

_____

_____

    b) ***Later that _____ Day _____ Night:***

_____

_____

_____

    c) ***The next _____ Day _____ Days:***
33. Check symptoms that are apparent ***since*** the accident:

( ) headache	( ) loss of smell	( ) numbness in fingers
( ) neck pain/stiffness	( ) loss of taste	( ) cold hands
( ) mid back pain	( ) loss of memory	( ) cold feet
( ) low back pain	( ) fatigue	( ) diarrhea
( ) eyes sensitive to light	( ) tension	( ) constipation
( ) pain behind eyes	( ) shortness of breath	( ) chest pain
( ) dizziness	( ) irritability	( ) nervousness
( ) fainting	( ) depression	( ) cold sweats
( ) ringing/buzzing ears	( ) sleeping problems	( ) anxious
( ) loss of balance	( ) numbness in toes	

    ( ) other _____
34. Occupation: _____ Employer: _____
35. Have you missed time from work? Yes/No
36. If yes, Full-time off work: dates _____ to _____
    Part-time off work: dates _____ to _____
37. Have you been unable to work since the accident? Yes/No
38. Did you seek medical help immediately/soon after the accident? Yes/No
39. If yes, how did you get there?
    ( ) someone else drove me ( ) ambulance
    ( ) drove own car ( ) police
    ( ) other _____

40. ***DOCTOR 1/HOSPTIAL/CLINIC SEEN*:** _____ date _____
41. Were you examined? Yes/No
42. Were X-rays taken? Yes/No
43. If yes, of what body parts?

_____

44. What treatment was given to you?
    ( ) bed rest ( ) brace ( ) physiotherapy
    ( ) adjustments ( ) medications ( ) other _____
45. What benefits did you receive from the treatment?

_____

_____

46. Date of last treatment: _____
47. ***DOCTOR 2/HOSPTIAL/CLINIC SEEN*:** _____ date _____
48. Were you examined? Yes/No
49. Were X-rays taken? Yes/No
50. If yes, what body parts? _____
51. What treatment was given to you?
    ( ) bed rest ( ) brace ( ) physiotherapy
    ( ) adjustments ( ) medications ( ) other _____
52. What benefits did you receive from the treatment?

_____

_____

53. Date of last treatment: _____
54. ***DOCTOR 3/HOSPTIAL/CLINIC SEEN*:** _____ date _____
55. Were you examined? Yes/No
56. Were X-rays taken? Yes/No
57. If yes, what body parts? _____
58. What treatment was given to you?
    ( ) bed rest ( ) brace ( ) physiotherapy
    ( ) adjustments ( ) medications ( ) other _____
59. What benefits did you receive from the treatment?

_____

_____

60. Date of last treatment: _____
61. Did you have any physical complaints ***just before the accident***? Yes/No
62. If yes, please explain in detail:

_____

_____

63. ***Prior*** to this accident, have you ***ever*** had symptoms similar to what you're experiencing now? Yes/No
64. If yes, please explain:

_____

_____

_____

(briefly include past falls, injuries, motor vehicle accidents, operations, etc.)

65. Do you notice any activities of your home daily routine which are different ***now*** than from ***before*** the accident? Yes/No
66. If yes, list them as:
67. Those that you are ***unable*** to do: _____
68. Those that are ***painful*** to do: _____
69. Those that are ***difficult*** to do: _____
70. Indicate on this diagram how the accident occurred:

80. Do you have an attorney on this case? Yes/No
    If yes, who?
    Name/Firm: _____
    Address: _____
    City _____ Postal Code_____

_____ _____
(PATIENT SIGNATURE) (DATE)

AUTOMOBILE ACCIDENT – INSURANCE DATA

1. Patient's Insurance Company Information:
Company Name: _____
Phone: _____
Address: _____City_____Postal Code_____
Policy #: _____
Adjuster's Name: _____
2. Insured's Insurance Information:
Insured's name if other than patient: _____
Phone: _____
Address: _____City_____Postal Code_____
Policy #: _____
Adjuster's Name: _____
3. Other Driver's Insurance Information:
Other Driver's Name (if another car was involved): _____
Phone: _____
Company Name: _____
Policy #: _____
Adjuster's Name: _____

MVA / WCB Symptom Checklist

History (Patient/Claimant to Complete)

Patient Name: _____ Date: _____

1. Symptom Checklist

For each symptom, check **YES (if present)** *or* **NO (if not present)**, *and rate severity on a scale of* **0** *to* **10** *where indicated* **0** *is* **"No Pain"** *and* **10** *is* **"Pain as Bad as it Could Be."**

Neck or shoulder pain ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Upper or Mid-back pain ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Low back pain ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Headache ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Arm(s) ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Hand(s) ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Face or Jaw ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Leg(s) ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Foot/Feet ☐ YES ☐ NO

No Pain — Pain as Bad as Could Be

0	1	2	3	4	5	6	7	8	9	10

Pain in Abdomen or Chest ☐ YES ☐ NO

No Pain — Pain as Bad as Could Be

0	1	2	3	4	5	6	7	8	9	10

Feeling of numbness, tingling in arms or hands ☐ YES ☐ NO

Feeling of numbness, tingling in legs or feet ☐ YES ☐ NO

Dizziness or unsteadiness ☐ YES ☐ NO

Vision problems ☐ YES ☐ NO

Hearing problems ☐ YES ☐ NO

Anxiety or worry ☐ YES ☐ NO

Nausea or vomiting ☐ YES ☐ NO

Difficulty swallowing ☐ YES ☐ NO

Problems concentrating ☐ YES ☐ NO

2. Loss of consciousness ☐ YES ☐ NO

3. Have the injuries prevent you from carrying out any of the following:

Explain

☐ Daily home activities _____

☐ Employment _____

☐ Schooling _____

☐ Sports or recreation _____

☐ Other _____

4. Do you think your injury will:

☐ get better soon

☐ get better slowly

☐ never get better

☐ don't know

Neck Pain And Disability Index (Vernon-Mior)

Patient Name: _____ 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 every day life. Please answer every section and mark in each section only the **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 causes extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on the 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 to 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 fair degree of difficulty in concentrating when I want to.
- ❑ I have a lot 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 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 hr. sleepless).
- ❑ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ❑ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ❑ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ❑ My sleep is completely disturbed (5-7 hrs. 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 a 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										Excruciating Pain
0	1	2	3	4	5	6	7	8	9	10

Low Back Pain And Disability Questionnaire (Revised Oswestery)

Patient Name: _____ 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 every day life. Please answer every section and mark in each section only the **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 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 increases the pain but I manage not 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 (i.e. on the 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 no pain when walking.
- ❑ I have some pain when 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 favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more then one hour.
- ❑ Pain prevents me from sitting more then a half hour.
- ❑ Pain prevents me from sitting more then 10 minutes.
- ❑ I avoid sitting because it increases pain immediately.

SECTION 5 – STANDING
- ❑ I can stand as long as I want without pain.
- ❑ I experience some pain while standing but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer then ½ hour without increasing pain.
- ❑ I cannot stand for longer than 10 minutes without increasing pain.
- ❑ I avoid standing because it increases the pain immediately.

SECTION 7 – SLEEPING
- ❑ I experience no pain in bed.
- ❑ I experience 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 (i.e. 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 – TRAVELING
- ❑ I experience no pain while traveling.
- ❑ I experience some pain while traveling but none of my usual forms of travel make it any worse.
- ❑ I experience extra pain while traveling but it does not compel me to seek alternative forms of travel.
- ❑ I experience extra pain while traveling 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 Scale (Rate the severity of your pain by checking one box on the following scale):

No Pain **Excruciating Pain**

0	1	2	3	4	5	6	7	8	9	10

Go to Application

Alberta Accident Benefits
Initial Claims Process

Overview

If you have been injured in an automobile accident in Alberta, you are entitled to accident benefits coverage regardless of whether you were at fault for the accident. The benefits you receive depend on the type of injury you have:

- If your injury is a sprain, strain or a whiplash associated with disorder I or II, your primary health care practitioner (chiropractor, medical doctor or physical therapist) does not have to seek approval of the insurer for payment for treatment of these injuries **if you provide notice of your claim**. Your primary health care practitioner will be able to bill the automobile insurer for all treatment services outlined in the "Diagnostic and Treatment Protocols" that are not covered by Alberta Health Care Insurance. These protocols have been developed in consultation with primary health care practitioners and are based on the best research and evidence currently available.

- For all other injuries, if you choose not to follow the diagnostic and treatment protocols, you will need to pay the health service provider for any services not covered by Alberta Health Care Insurance. You will be reimbursed for eligible expenses from your extended health care benefits (e.g., Blue Cross or similar employee benefits plan) and then by your automobile insurer.

What to do if you are injured in an Automobile Accident:

1. **See a Primary Health Care Practitioner** (chiropractor, medical doctor, physical therapist) as soon as possible for an assessment of your injury and, if needed, treatment advice.
2. **File an injury accident report with the police.**
3. **Complete the attached Notice of Loss and Proof of Claim Form (AB-1),** retain a copy for your records and send the original signed form(s) to the insurance company. If you are unable to send the form within the following timeframes, submit it to your insurance company as soon as practicable and explain the reason for the delay.
    - If your injury is diagnosed as a sprain, strain or whiplash associated disorder I or II, submit this form within 10 days of the accident so that you can access accident benefits described as the "Diagnostic and Treatment Protocols."
    - If you have other types of injuries, or you choose not to access the accident benefits described as the "Diagnostic and Treatment Protocols", submit the form within 30 days of the accident.
    - If a family member is fatally injured in the collision, you can access funeral, grief counselling and death benefits. This form should be submitted within 30 days of the accident.
4. **You will be contacted** about the benefits you are entitled to receive after the insurance company reviews your completed form. If your insurance company needs any additional information in order to process your application, they will contact you.

If you have further questions about this form, the process, or your benefits, please contact your claims adjuster. If you do not know who your claims adjuster is, contact your insurer or the Insurance Bureau of Canada at 1-800-377-6378.

Go to Application

Go to Application

Important Notice Concerning Your Personal Information

The personal information you provide in forms AB-1, AB-1a (Claim for Disability Benefits) or AB-2 (Treatment Plan) is collected under the authority of the Insurance Act, Alberta's Automobile Insurance Accident Benefits Regulation, Diagnostic and Treatment Protocols Regulation and all applicable privacy legislation.

- Your primary health care practitioner or dentist will need to collect personal information from you and from other health service providers and will need to use and disclose your personal information to provide you with appropriate diagnosis, treatment and care.
- Your insurance company and its agents will need to collect, use and disclose personal information from you, your primary health care practitioner, and other health service providers concerning the accident, your injuries, any pre-existing conditions that may impede your recovery progress, the amount of treatment and care provided to you, and any assessments of your injuries and indications as to your treatment progress in order to facilitate contact with you, to determine your eligibility for accident and/or disability income benefits, and to administer your claim.

Under applicable privacy legislation, it is necessary to obtain your consent to authorize the sharing of your personal information as specified above. The legislation also regulates how primary health care practitioners, dentists, other health service providers, and insurance companies can use and disclose your information once they have it. Section 2 of form AB-1 will ask for your consent or that of your agent. Refusal to provide your authorization and consent could result in an inability to provide you with the treatment and care you require (if not covered by Alberta Health Care Insurance) and may result in an inability for your insurance company to process your claim, in whole or in part.

Your primary health care practitioner, dentist or other health service provider and insurance company will retain and rely on a copy of your consent for the period of time that your treatment and care is ongoing and your claim is active. You may revoke your consent at any time in writing to your primary health care practitioner or dentist and your insurer or any other person to whom you give consent, subject to continuing legal obligations. If you have any questions concerning the collection, use or disclosure of your personal information, please ask your primary health care practitioner, dentist, or your insurance claims representative or adjuster.

Go to Application

You will need Acrobat Reader 6.0 or higher in order to complete this form online.

Read Instructions

Important Notice About Your Personal Information

Notice of Loss and Proof of Claim

Form AB-1

Print

This form is effective on **November 20, 2004** for accidents that occur on or after **October 1, 2004**

Send this form to the appropriate insurer:	To be completed by Insurer	
Fax # (____)_____-_____	Claim Number	
	Insurance Company	
	Claim Representative	
	Policy Number	
	Date of Accident: (DD-MM-YYYY)	

Section 1: Claimant Information

Part 1 – Claimant Information

Last Name	First Name	Middle Name(s)
Address		
City, Town or County	Province	Postal Code
Telephone Number (Home) *(Include area code)*	Telephone Number (Work) *(Include area code)*	Fax Number *(Include area code)*
Date Of Birth *(DD/MM/YYYY)*	Gender ☐ Male ☐ Female	You can best be reached: ☐ By telephone ☐ At home ☐ By personal visit ☐ At work ☐ Other
When is the best time to reach you?	Day(s) of the week:	
Insurance Company	Policy Number	
Will this be an Alberta Workers' Compensation Board Claim? ☐ Yes ☐ No	Are Extended Health Care Benefits Available? (e.g., Blue Cross or similar Employee benefits plans) ☐ Yes ☐ No Details:	
Are you currently employed or engaged in training activities? ☐ Full Time ☐ Part Time ☐ Self-employed ☐ Retired ☐ Student ☐ Not employed		If you are making a claim for disability benefits, please also complete Form AB- 1a.

Part 2 – Claimant's Authorized Representative Information (if applicable)

Last Name	First Name	Middle Name(s)
Address		
City, Town or County	Province	Postal Code
Relationship with Claimant ☐ Parent ☐ Guardian ☐ Other	Relevant Documentation Attached? If no, please authorize your representative by completing Part 5 of this form. ☐ Yes ☐ No ☐ Not Applicable	
Telephone Number (Home) *(Include area code)*	Telephone Number (Work) *(Include area code)*	Fax Number *(Include area code)*

Part 3 – Claimant's Accident Details *(If more space is required please continue on back side of this page)*

You were a:
☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other

Location of Accident	City, Town or County	Province

Time of Accident: ____ : ____ ☐ a.m. ☐ p.m.	Date of Accident *(DD/MM/YYYY)*	Was Accident Reported to the Police? ☐ Yes ☐ No	Date Reported *(DD/MM/YYYY)*

Please provide a brief description of how the accident occurred and how you were injured:

Have you seen a Medical Doctor, Physical Therapist, Chiropractor, Dentist or other health service provider for diagnosis, treatment and care for an injury related to this accident?
☐ Yes ☐ No ☐ Appointment booked for:

Have you started treatment?
☐ Yes ☐ No ☐ Appointment booked for:

Are you currently receiving medical or rehabilitation benefits related to another motor vehicle accident?
☐ Yes ☐ No

Please provide a brief description of your injuries and the symptoms that you are currently experiencing:

Part 4 – Information of Health Provider Providing Ongoing Treatment and Care

Name of Primary Health Care Practitioner or Dentist	Profession

Address		

City, Town or County	Province	Postal Code

Telephone Number *(Include area code)*	Fax Number *(Include area code)*

Section 2: Certification and Consent to Share Information

Part 5 – Authority to Act on Claimants Behalf
(this section should be completed only when the claimant chooses not to act on his/her own behalf)

I, _____, hereby authorize _____ to act as my representative concerning the treatment and care of my injury, the submission and ongoing handling of my claim for accident and/or disability income benefits and the collection, use and disclosure of information concerning my injury, diagnosis, assessment, treatment or care resulting from the automobile accident referred to in Section 1 of this form.

I authorize my primary health care practitioner(s), dentist(s), other health service provider(s) and my insurance company, _____ and their agents, to collect relevant information concerning me and my accident from my representative as required. I further authorize primary health care practitioner(s), dentist(s), other health service provider(s) and my insurance company to disclose relevant information concerning my injury, diagnosis, assessment, treatment and care and my claim for accident and/or disability income benefits to my representative.

Signature of Claimant _____

Date_____

Signature of Authorized Representative _____

Date_____

Part 6 – Certification and Consent to Share Information

(to be completed by claimant or their authorized representative)

I certify that the information provided is true and correct to the best of my knowledge.

I authorize all assessing or treating Primary Health Care Practitioners, dentist(s) or other health service provider(s) to collect, use and disclose any relevant information concerning my injury, including diagnosis, assessment, treatment or care resulting from the automobile accident referred to in Section 1 herein, for the purpose of providing ongoing treatment and care.

I further authorize all assessing or treating Primary Health Care Practitioners, dentist(s) or other health service providers to disclose my personal information to my insurance company, _____ and their agents that is relevant for the purpose of determining my eligibility for accident and disability benefits as outlined on Form AB-1 and for the purpose of administering my claim.

I further authorize my insurance company and its agents to collect, use and disclose relevant information concerning my injury, diagnosis, assessment, treatment or care received as a result of the automobile accident referred to in Section 1 herein, including a treatment plan and services provided, for the purpose of determining my eligibility for accident and disability benefits as outlined on Form AB-1 and administering my claim.

☐ I am the claimant or ☐ I am the authorized representative of the claimant

Signature _____ Date_____

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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment FORM L

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures.

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence there is a stroke already in progress. However you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment although no scientific evidence has demonstrated such injuries are caused or may be caused by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed or have been offered the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general including spinal adjustment, the treatment options, and recommendations for my condition and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day_____, 20 _____.

_____ _____

Patient Signature or Legal Guardian | Witness of Signature

Name:_____ Name:_____

(please print) (please print)

Beacon Hill Chiropractic & Massage
Dr. Michael Schmolke and Associates
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