February 2019 **CHIROPRACTIC NEW PATIENT - INTAKE FORM**

PATIENT HEALTH RECORD

As a full spectrum chiropractic clinic; we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stress that can accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Please complete this document so we are better able to address your specific health concerns and challenges. Chiropractic is great for a variety of reasons. Pain relief, injury recovery, mobility improvement, and correction of whatever is malfunctioning in the body, are all areas of healthcare our doctors are capable of treating.

Were you aware that:
◯ Y ◯ N - Doctors of Chiropractic work with the nervous system?
◯ Y ◯ N - The nervous system controls all bodily functions and system?

Full Name: ______________________ ***M / F*** ***AHC #:*** __________

Date of Birth (M/D/Y): __________ **Age:** ____ **Occupation:** __________

Address: ______________________ **City:** __________ **Prov:** ____ **Postal Code:** ______

Home phone: __________ **Cell phone:** __________ **Work Phone:** __________

◯ **Single** ◯ **Married** ◯ **Divorced** ◯ **Separated** ◯ **Widowed** **Children? Y / N** **How Many?:** ______

Name of Spouse: ______________________ **Phone Number:** __________

Alternate Emergency Contact: ______________________ **Phone Number:** __________

If under 18, Name of Parents: ______________________

Do you consent to emails regarding appointment reminders and clinic/health information? ___ **Yes** ___ **No**

Email: ______________________ **Initials:** __________

How were you referred to Beacon Hill Chiropractic & Massage?

◯ Online ◯ Website ◯ Walk by ◯ Lives in area ◯ Other: ______ ◯ Person: __________

◯ Current patient: __________

Experience with Chiropractic

Have you ever been adjusted by a Chiropractor before? ◯ Yes ◯ No How long ago? __________

Doctor's name? __________ Reason for visit? __________

REASON FOR THIS VISIT

Is this visit due to or in any way related to: ◯ Job ◯ Sport ◯ Car accident ◯ Fall ◯ Chronic discomfort ◯ Injury ◯ Other

If job related, have you reported your accident to your employer? Y / N **Will this visit be part of a WCB claim?** Y / N

If motor vehicle related, will this visit be part of a MVA claim? Y / N

Please describe the reason for your visit: ______________________

When did this condition begin? __________ Has it gotten: ◯ Worse ◯ Better ◯ Stayed the same ◯ Comes/goes

Does this condition interfere with: ◯ Work/School ◯ Sleep ◯ Daily routine ◯ Exercise/Athletics

Please explain: ______________________

Have you seen anyone else for this condition? Doctor/clinician's name: ______________________

Type of treatment: __________ Result: __________

FULL NAME: ____________________________

Please **CHECK** any current/past conditions

CARDIOVASCULAR
- ◯ Angina
- ◯ Blood clots
- ◯ Blood pressure: HIGH
- ◯ Blood pressure: LOW
- ◯ Congenital heart defect
- ◯ Hardening of arteries
- ◯ Heart attack
- ◯ Heart murmur
- ◯ Heart surgery
- ◯ Hemophilia
- ◯ Pace maker
- ◯ Poor circulation
- ◯ Stroke
- ◯ Thrombosis
- ◯ Varicose veins

RESPIRATORY
- ◯ Asthma
- ◯ Chest pain
- ◯ Difficulty breathing
- ◯ Emphysema (short of breath)
- ◯ Pneumonia
- ◯ Pulmonary hypertension
- ◯ Tuberculosis

GASTROINTESTINAL
- ◯ Constipation
- ◯ Crohn's or Colitis
- ◯ Digestive problems
- ◯ Gallbladder/Jaundice
- ◯ IBS or IBD
- ◯ Nausea/Vomiting
- ◯ Ulcers

MUSCLE/BONE/JOINT/DISC
- ◯ Ankle swelling
- ◯ Arthritis
- ◯ Back pain
- ◯ Bursitis
- ◯ Cortisone injections
- ◯ Degenerative disease
- ◯ Fractures/Breaks: ____________
- ◯ Inflammation
- ◯ Osteopenia
- ◯ Osteoporosis
- ◯ Plates/Pins
- ◯ Rheumatoid arthritis
- ◯ Sciatica
- ◯ Scoliosis
- ◯ Pain b/w shoulder blades
- ◯ Spinal disc problems
- ◯ Sprain/Strain
- ◯ Trauma/Falls
- ◯ Weakness/Instability

HEAD & NECK
- ◯ Dizziness
- ◯ Ear infection
- ◯ Headache
- ◯ Hearing loss
- ◯ Neck pain
- ◯ Difficulty with swallowing
- ◯ Ringing in ears (tinnitus)
- ◯ Sinus problems
- ◯ Sleep loss
- ◯ TMJ disorder
- ◯ Vertigo
- ◯ Vision problems
- ◯ Whiplash

NEUROLOGICAL
- ◯ Alzheimer's/dimentia
- ◯ Brain injury
- ◯ Cerebral palsy
- ◯ Epilepsy
- ◯ Fainting
- ◯ Migraines
- ◯ Loss of motor control
- ◯ Meningitis
- ◯ Multiple Sclerosis (MS)
- ◯ Narcolepsy/Insomnia
- ◯ Nerve damage: ________
- ◯ Numbness in arms/legs/ hands/feet/__________
- ◯ Parkinson's/ Seizures

SKIN CONDITIONS
- ◯ Keloid/Scarring
- ◯ Psoriasis
- ◯ Shingles
- ◯ Warts

WOMEN ONLY
- ◯ Cramps/back pain
- ◯ Infertility issues
- ◯ Irregular cycles
- ◯ Menopause
- ◯ Miscarriage
- ◯ New mother
- ◯ Nursing
- ◯ Painful menstruation
- ◯ Pregnant

DIAGNOSED CONDITIONS
- ◯ ADD/ADHD
- ◯ Autoimmune disease
- ◯ Cancer: ____________ (radiation/chemotherapy)
- ◯ Diabetes (I / II)
- ◯ Hepatitis
- ◯ HIV/AIDS
- ◯ Hypertension
- ◯ Infectious disease: ____________
- ◯ Kidney disease
- ◯ Raynaud's
- ◯ Thyroid problems
- ◯ Tuberculosis
- ◯ Urinary system issues
- ◯ Other:____________

MENTAL HEALTH
- ◯ Alcohol/drug abuse
- ◯ Anxiety
- ◯ Bipolar disorder
- ◯ Depression
- ◯ Eating disorder
- ◯ Panic attacks
- ◯ Postpartum depression
- ◯ Psychiatric issues
- ◯ PTSD
- ◯ Stress

ALLERGIES

Allergic to: ____________

Reaction: ____________

◯ EpiPen? YES / NO

MEDICATIONS/SUPPLEMENTS

Some drugs can cause neuro-musculoskeletal symptoms. It is important for our chiropractors to know what medications you are currently taking. Symptoms you present in clinic may be related to these medications. If you are unsure of your medications it is imperative that you let us know at your next visit.

- ◯ Acid reducers
- ◯ Birth control
- ◯ Blood thinners
- ◯ Muscle relaxers
- ◯ Stimulants
- ◯ Antidepressants
- ◯ Blood pressure meds
- ◯ Insulin
- ◯ Pain killers (NSAIDS/Ibuprofen)

Medications	Dosage	Duration	Reason

Nutritional supplements	Dosage	Duration	Reason

FULL NAME: ______________________________

FAMILY HEALTH HISTORY

- ◯ Arthritis
- ◯ Cancer
- ◯ Depression
- ◯ Diabetes
- ◯ Digestive issues/IBS
- ◯ Heart disease
- ◯ High blood pressure
- ◯ Multiple sclerosis
- ◯ Osteoporosis
- ◯ Stroke

HEALTH & LIFESTYLE

	YES	NO	Frequency
Smoking			/day
Alcohol			/day
Coffee			/day
Cannabis			/day
CBD Oil			/day

Please note that treatment will be withheld for any patient under the influence of alcohol or non-prescription drugs

How frequently do you consume/participate in the following ***per day****?*	0	1-2	3-4	5-6	7-9	10+
Glasses of water						
Fruits/vegetables						
Sugary treats						
Salty treats						

How frequently do you participate in the following ***per week****?*	0x	1x	2-3x	4-5x	6+
Cardio exercise					
Strength training					

Describe your sleep habits: ______________________________

How would you describe your energy? ______________________________

Do you wear foot support/orthotics? ◯ Yes ◯ No

STRESS HISTORY – please list your current/past stressors

Biggest PHYSICAL stressors: ______________________________

Most significant CHEMICAL/NUTRITIONAL stressors: ______________________________

Source of MENTAL/EMOTIONAL stress: ______________________________

Past motor vehicle accident? ◯ Yes ◯ No Date of accident: ______________________________

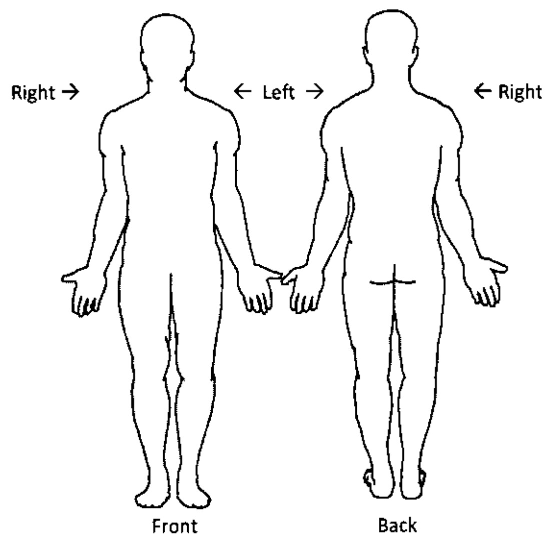
Past surgeries? ◯ Yes ◯ No Please list: ______________________________

____

PAIN/DISCOMFORT DIAGRAM:

Please mark these diagrams according to where you feel pain. Please also indicate which sensations you feel by referring to the key below:

KEY
///// Stabbing
XXXX Aching
Burning
>>>> Pins/Needles
0000 Numbness



PLEASE CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

0-3 – No pain; Mild pain **4-7** – Moderate pain; medication required **8-10** – Severe pain; daily life impacted

May 2019

CHIROPRACTIC MVA FORM

PERSONAL INJURY – PATIENT DATA FORM

NAME: ______________________ **DATE:** ______________________

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 the car? ______________________
7. What was the approximate cost of damage done to your vehicle? $ ______________
8. Visibility at the time of accident: ◯ Poor ◯ Fair ◯ Good ◯ Other
   Please describe: ______________________
9. Road conditions at time of the accident: ◯ Icey ◯ 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 collision
    - ◯ 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)
    If yes, did you brace for the accident? (YES / NO)
14. Were seat belts worn? (YES / NO)
15. Were shoulder harnesses worn? (YES / NO)
16. Does your car have headrests? (YES / NO)
    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*
17. Was the car braking? (YES / NO)
18. Was your car moving at the time of the accident? (YES / NO)
    If yes, how fast would you estimate you were going? ________ (km/hour)
19. How fast was the other vehicle traveling? ________ (km/hour)
20. 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: ______________________

FULL NAME: ____________________________________

21. At the time of the accident, recall what parts of your *head or body* hit parts of the inside of your car. Please specify: ____________________________________
____
22. As a result of the accident were you:
◯ Rendered unconscious ◯ Dazed, circumstances vague ◯ Other: ________________
23. Could you move all parts of your body? (YES / NO)
If no, what parts and why?
____
24. Were you able to get out of the car and walk unaided? (YES / NO)
If no, why not?____________________________________
25. What bleeding cuts did you get from the accident? ____________________
26. What bruises did you get from the accident? ____________________
27. Please describe how you felt (be specific):
Immediately after the accident:____________________________________
____
Later that _____***Day*** _____ ***Night:***____________________________
____
The next _____***Day*** _____***Night:***____________________________
____
28. Check symptoms that are apparent *since* the accident:

◯ Anxious	◯ Eyes sensitive to light	◯ Neck pain/stiffness
◯ Chest pain	◯ Fainting	◯ Nervousness
◯ Cold feet	◯ Fatigue	◯ Numbness in fingers
◯ Cold hands	◯ Headache	◯ Numbness in toes
◯ Cold sweats	◯ Irritability	◯ Pain behind eyes
◯ Constipation	◯ Loss of balance	◯ Ringing/buzzing ears
◯ Depression	◯ Loss of memory	◯ Shortness of breath
◯ Diarrhea	◯ Loss of smell	◯ Sleeping problems
◯ Dizziness	◯ Loss of taste	◯ Tension
◯ Mid back pain	◯ Low back pain	

◯ Other: ____________________________________

29. Occupation: ____________________ Employer: ____________________
30. Have you missed time from work? (YES / NO)
If yes, Full-time off work: dates ____________ to ____________
Part-time off work: dates ____________ to ____________
31. Have you been unable to work since the accident? (YES / NO)
32. Did you seek medical help immediately/soon after the accident? (YES / NO)
33. If yes, how did you get there?
◯ Drove own car ◯ Someone else drove me ◯ Ambulance ◯ Police ◯ Other: __________

FULL NAME: ____

34. ***Doctor 1/Hospital/Clinic seen:*** ____________________________ ***Date:*** ____________
35. Were you examined? (YES / NO)
36. Were x-rays taken? (YES / NO)
    If yes, of what body parts? ____
37. What treatment was given to you?
    - ◯ Adjustment ◯ Brace ◯ Physiotherapy
    - ◯ Bed rest ◯ Medications ◯ Other: ________________
38. What benefits did you receive from the treatment?
    ____
    ____
39. Date of last treatment: ____________________
40. ***Doctor 2/Hospital/Clinic seen:*** ____________________________ ***Date:*** ____________
41. Were you examined? (YES / NO)
42. Were x-rays taken? (YES / NO)
    If yes, of what body parts? ____
43. What treatment was given to you?
    - ◯ Adjustment ◯ Brace ◯ Physiotherapy
    - ◯ Bed rest ◯ Medications ◯ Other: ________________
44. What benefits did you receive from the treatment?
    ____
    ____
45. Date of last treatment: ____________________
46. ***Doctor 3/Hospital/Clinic seen:*** ____________________________ ***Date:*** ____________
47. Were you examined? (YES / NO)
48. Were x-rays taken? (YES / NO)
    If yes, of what body parts? ____
49. What treatment was given to you?
    - ◯ Adjustment ◯ Brace ◯ Physiotherapy
    - ◯ Bed rest ◯ Medications ◯ Other: ________________
50. What benefits did you receive from the treatment?
    ____
    ____
51. Date of last treatment: ____________________

52. Did you have any physical complaints ***just before the accident?*** (YES / NO)
    If yes, please explain in detail: ____
    ____
53. ***Prior*** to this accident, have you ***ever*** had symptoms similar to what you're experiencing now?
    (YES / NO)
    If yes, please explain in detail: ____
    ____
    (briefly include past falls, injuries, motor vehicle accidents, operations... etc.)

FULL NAME: ____

54. Do you notice any activities of your home daily routine which are different ***now*** than from ***before*** the accident? (YES / NO)

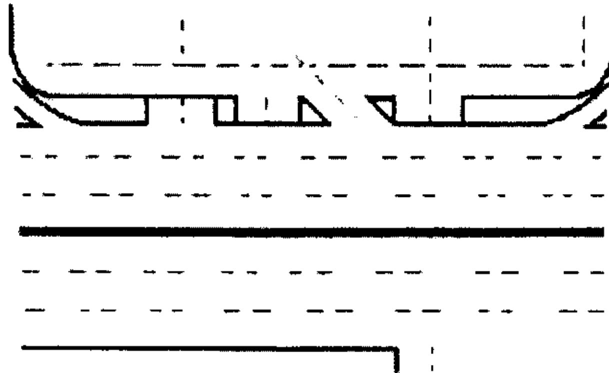
    If yes, list them as:

    a. Those you are ***unable*** to do: ______________________________

    b. Those that are ***painful*** to do: ______________________________

    c. Those that are ***difficult*** to do: ______________________________

55. Indicate on this diagram how the accident occurred:



56. Do you have an attorney on this case? (YES / NO)

    Name/Firm: ______________________________

    Address: ______________________________

    City: ____________________ Postal Code: ____________________

______________________________ ______________________________

(PATIENT SIGNATURE) *(DATE)*

AUTOMOBILE ACCIDENT

1. **Patient's insurance company information**

   Company name: ______________________________

   Address: ____________________ Phone #: ____________________

   City: ____________________ Postal Code: ____________________

   Policy #: ____________________ Adjustors name: ____________________

2. **Insured's insurance information**

   Insured's name if other than patient: ______________________________

   Address: ____________________ Phone #: ____________________

   City: ____________________ Postal Code: ____________________

   Policy #: ____________________ Adjustors name: ____________________

3. **Other driver's insurance information**

   Other driver's name (if another car was involved): ______________________________

   Company name: ____________________ Phone #: ____________________

   Policy #: ____________________ Adjustors 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

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, physician 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 Regulation (DTPR) 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 DTPR, you will need to pay health service providers 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** 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 Form),** retain a copy for your records and send the original signed form(s) to the insurer of the vehicle you were in at the time of the accident (insurance company). If you are unable to send the form within the following timeframes, submit it to the 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 business days of the accident so that you can access accident benefits described in the DTPR.
   - If you have other types of injuries, or you choose not to access the accident benefits described in the DTPR, submit the form within 30 days of the accident.
   - If you have other types of injuries, or you choose not to access the accident benefits described in the DTPR, submit the form 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 the 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 the insurance company or the Insurance Bureau of Canada at 1-800-377-6378.

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 Alberta's *Insurance Act,* Automobile Insurance Accident Benefits Regulations, 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.

- The 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. Parts 5 and 6 of form AB-1 will ask for your consent or that of your Authorized Representative. 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 the insurance company to process your claim, in whole or in part.

Your Primary Health Care Practitioner, dentist or other health service provider and the 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 the insurance company 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.

Notice of Loss and Proof of Claim (Form AB-1)

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

Part 1: Claimant Information

Last Name	First Name	Middle Name(s)

Mailing Address	City or Town

Province	Country	Postal Code	Email Address

Telephone Number (Home)	Telephone Number (Work)	Telephone Number (Cell)	Date of Birth *(dd-mm-yyyy)*	Gender
			- -	☐ Male ☐ Female

You can best be reached:

☐ at home/cell ☐ at work ☐ other (personal visit/email): ______________________

When is the best time to reach you (include days of the week)?	Will this be an Alberta Worker's Compensation Board Claim? ☐ Yes ☐ No

Are Extended Health Care Benefits Available? (e.g. Blue Cross or similar Employee benefit plans) ☐ Yes ☐ No — Provide details (including plan name):

Are you currently employed or engaged in training activities?

☐ Full Time ☐ Part Time ☐ Seasonal *(provide job and title)*: ______________________

☐ Self-employed ☐ Retired ☐ Student ☐ Not employed

If you are making a claim for disability benefits, please also complete Form AB0001a.

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

Last Name	First Name	Middle Name(s)

Mailing Address

City or Town	Province	Country	Postal Code

Telephone Number (Home)	Telephone Number (Work)	Telephone Number (Cell)	Fax Number

Relationship with Claimant

☐ Parent ☐ Guardian ☐ other: ______________________

Relevant Documentation Attached? ***If no, please authorize your Authorized Representative by completing Part 5 of this form.***

☐ Yes ☐ No

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 or Town	Province	Country

Date of Accident *(dd-mm-yyyy)*	Time of Accident ___ : ___ ☐ a.m. ☐ p.m.	Was the accident reported to the police? ☐ Yes ☐ No

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

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

Have you started treatment?
☐ Yes ☐ No Appointment was/is 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

Full Name of Primary Health Care Practitioner or Dentist	Profession

Mailing Address

City or Town	Province	Country

Telephone Number	Fax Number

Part 5: Authority to Act on Claimant's 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 Authorized 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 Parts 1 through 4 of this form.

I authorize my Primary Health Care Practitioner(s), dentist(s), other health service provider(s) and the insurance company,

and their agents, to collect relevant information concerning me and my accident from my Authorized Representative as required. I further authorize Primary Health Care Practitioner(s), dentist(s), other health service provider(s) and the 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 Authorized Representative.

Date *(dd-mm-yyyy)*	Signature of Claimant

Date *(dd-mm-yyyy)*	Signature of Authorized Representative

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 Parts 1 through 4 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 the 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 the 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 Parts 1 through 4 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.

Name	Date *(dd-mm-yyyy)*	Signature

This Section to be Completed by Insurer		
Insurance Company		Policy Number
Date of Accident *(dd-mm-yyyy)*	Full Name of Claims Representative	Claim Number

Please forward this form to the Insurance Company.

Part 7: Choice in Following Diagnostic and Treatment Protocols Regulation

Please state whether you choose to be treated within the Diagnostic and Treatment Protocols Regulation.

☐ I choose to be treated within the Diagnostic and Treatment Protocols Regulation as indicated on Form AB-1 (Notice of Loss and Proof of Claim).

☐ I choose **not to** be treated within the Diagnostic and Treatment Protocols Regulation.

I certify that the information provided is true and correct to the best of my knowledge. I confirm that I have consented to the collection, use and disclosure of my personal information for my treatment and care and determination of my eligibility for accident and/or disability income benefits as outline on Form **AB-1** (Notice of Loss and Proof of Claim).

☐ I am the claimant, OR ☐ I am the Authorized Representative of the claimant.

Name	Date *(dd-mm-yyyy)*	Signature

This Section to be Completed by Claimant / Authorized Representative or a Primary Health Care Practitioner		
Insurance Company		Policy Number
Date of Accident *(dd-mm-yyyy)*	Full Name of Claims Representative	Claim Number

Please forward this form to the Insurance Company.

Beacon Hill Chiropractic and Massage

Payment Authorization Regarding MVA Claims

Please note, on rare occasions, insurance companies do not authorize claims. If your insurance company does not authorize any part of your claim, it is your responsibility as our patient to pay for your chiropractic/massage/acupuncture treatments and any related rehabilitative products or supplements.

As well, if appointments are cancelled or an appointment is missed without 24-hours notice, you will be charged a cancellation fee.

Name: ______________________________

Credit Card Number: ______________________ **Expiry Date:** ____________

Signed: ______________________________ **Date:** ______________

Witness Name: ____________________ **Witness Signature:** ____________________

MVA claim number: ______________________________

Beacon Hill Chiropractic & Massage. 11636 Sarcee Trail NW. Calgary, AB. T3R 0A1. 403-516-1141.