Holroyd Family Chiropractic Inc.

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MOTOR VEHICLE ACCIDENT HISTORY

Name: _____ Date: _____
ICBC CLAIM NUMBER: _____ Adjuster's Name:_____
Have you retained an attorney? ○Yes ○No If yes, name and address of attorney: _____
_____
Location of the accident:_____
Date of the accident: _____ Time of accident: _____
What were the weather conditions: _____
State how the accident happened in your own words:_____
_____
_____
_____

Direction of impact: ○Rear-end ○Head-on ○Hit on driver side ○Hit on passenger side ○Other

☐I was the driver ☐Front passenger seat ☐Rear seat passenger (Left Right Center)

Were you stopped at the time of the impact? ○Yes ○No

Were you applying your brakes? ○Yes ○No

Estimate your speed: ____ km/hr Their speed: ____ km/hr

Vehicle: (year, make, model) _____

Movement of the patient in the car:_____
_____

Seatbelt? ○Yes ○No Shoulder belt? ○Yes ○No Head rest: ☐None ☐Integral ☐Up ☐Down

Did you hit your head or lose consciousness? _____

Was the car towed away? ○Yes ○No

Did you go to the hospital? ○Yes ○No If yes, what was done and were you admitted?_____
_____

How did you get home? _____

Have you seen any other doctors? ○Yes ○No If yes, what treatment have you had and has it helped?_____

Are you taking any medications? ○Yes ○No If yes, what:_____

When did you have symptoms after the accident?
☐Immediately ☐A few hours later ☐8 hours later ☐Next day ☐Two days later ☐Other: _____

Has your condition improved, worsened, or stayed the same since the accident? _____

Have you missed work due to the accident? ○Yes ○No If yes, how much?_____

Are you working in pain? ○Yes ○No

Are you working decreased hours due to the pain? ○Yes ○No

OVER

Please draw appropriate symbols on body for your current areas of concern:

ACHE – A
BURNING – B
NUMBNESS – N
PINS AND NEEDLES – P
STABBING – S
THROBBING – T
STIFFNESS – F