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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

Your 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

How did you get home? _____

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

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:_____
_____
What symptoms have you had after the accident?_____
_____
_____
_____

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

Do you have any abnormal sensations and/or muscle weakness? □Yes □ No
Please explain:_____

Has your condition improved, worsened, or stayed the same since the accident? _____
_____
How has this affected your activities of daily living? (Example: play/chores/recreation/hobbies etc.)
_____
_____
_____

Are you currently working? □ Yes □ No

Are you employed or engaged in training activities?
□ Full Time □ Part Time □ Self-Employed □ Seasonal □ Training/Apprenticeship □ Student
□ Retired □ Not Employed

Have you been absent from the following as a result of the MVA?
Work: □Yes □No **Training:** □Yes □No **School/Studies**: □Yes □No

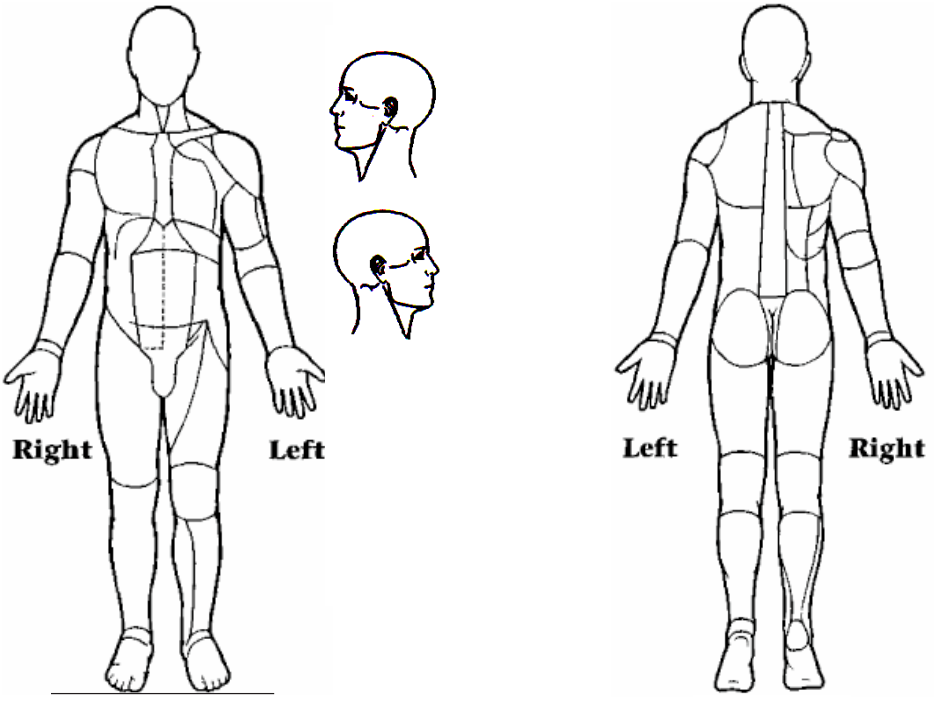
***If you are continuing to work/study/train, please indicate the status, as applicable**

STATUS OF DUTUES
Work: □Full □Modified **Training:** □Full □Modified **Study:** □Full □Modified

STATUS OF HOURS
Work: □Full □Modified **Training:** □Full □Modified **Study:** □Full □Modified

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



□ I give my consent to share all information related to the history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC

SIGNATURE:_____