CHIROPRACTIC MOTOR VEHICLE ACCIDENT FORM
OFFICE OF DR. JOAN DAVIDSON & DR. BEVERLY TYLER

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ICBC CLAIM #_____ ADJUSTER:_____ PHONE:_____

1. Your name: _____ Today's Date: _____
   Birth date: _____ Age:_____ Height: _____ Weight: _____
2. Date of Accident: _____ Time of Accident: _____am/pm
3. Describe the accident and its severity, including location: _____
   _____
   _____
   _____
4. List of information of the vehicle you were in: Year: _____ Make:_____ Model: _____
5. List of information of the other vehicle: Year:_____ Make: _____ Model: _____
6. Road conditions at time of the accident: WET DRY ICY OTHER_____
7. Were you hospitalized? YES NO WHEN & WHERE? _____
8. How did you get to the hospital? _____
9. Were there x-rays taken? YES NO WHEN & WHERE? _____
10. What did the hospital do for your injuries? _____
11. How long did you stay at the hospital? _____
12. What bleeding cuts or bruises did you sustain in this accident? _____
13. Where were you seated in the vehicle? _____
14. Were you wearing a seat belt? YES NO What type? LAP SHOULDER/LAP
15. Did you receive any injury or bruise form the seat belt? YES NO WHERE? _____
    _____
16. Were you aware there was going to be an impact? YES NO
17. Did you lose consciousness (black out) after impact? YES NO
18. At the accident scene did you become (please circle all that apply):
    CONFUSED DISORIENTED LIGHT-HEADED DIZZY
    NAUSEATED BLURRED VISION RING/BUZZ IN EARS
    OTHER: _____
19. If you still have any of the above symptoms, which ones? _____
20. Are you currently suffering from any of the following? (please circle all that apply)

RESTLESSNESS	IRRITABLE
DIFFICULTY CONCENTRATING	DIFFICULTY WITH MEMORY
SLEEPLESSNESS	FORGETFULNESS
REDUCED TOLERANCE TO HEAT	REDUCED TOLERANCE TO ALCOHOL

PLEASE INCLUDE ANY OTHER SYMPTOMS THAT YOU ARE EXPERIENCING AS A RESULT OF THE ACCIDENT:_____
_____
_____
_____

21. Was the vehicle equipped with a headrest? YES NO If yes, where did the top of the headrest contact with your head? _____
22. Was your vehicle moving at the time of the collision? YES NO At what speed? _____
23. Was the other vehicle moving at the time of the collision? YES NO At what speed? _____
24. If the other vehicle moving at the time of collision, was it (please circle)

SLOWING DOWN GAINING SPEED TRAVELING AT A STEADY SPEED

25. Was your car stopped at the time of impact? YES NO

26. If no, then estimate the speed of the vehicle you were in: _____

27. If yes, was the driver's foot also on the brake? YES NO
Was the driver's foot on the clutch? YES NO NO CLUTCH

28. If your vehicle was moving at the time of impact, was it (please circle):
SLOWING DOWN GAINING SPEED TRAVELING AT A STEADY SPEED

29. On what part of the automobile did your following body parts hit?
Head _____ Chest _____
Right/Left Shoulder_____ Right/Left Arm _____
Right/Left Hip _____ Right/Left Leg _____
Right/Left Knee _____ Other _____

30. Did any of the following car parts break during the accident? (please circle)
WINDSHIELD FRONT/BACK SEATBELT RIGHT/LEFT SIDE WINDOW
STEERING WHEEL OTHER_____

31. Was the trunk of your body pointed straight forward at the time of the collision? YES NO
If no, how was it turned? _____
_____

32. Was your head pointed straight forward? YES NO
If no, how was it turned? _____
_____

33. Since your motor vehicle accident, have you been unable to work? YES NO
If yes, list dates: _____
_____
_____

34. If you have kept working, have you modified your work duties in any way as a result of your injuries? YES NO If yes, describe: _____
_____
_____

35. Have you modified your usual daily activities such as housework, leisure, sports in any way as a result of your injuries? YES NO If yes, describe: _____
_____