ICBC Personal Injury Questionnaire

All information taken by our team is confidential and will be used for the purpose of enhancing your care in the clinic.

Name *FIRST & LAST*

Date of Accident *DD/MM/YYYY*

Where did your accident happen? Describe the accident in your own words:

What was your position in the car?

◯ Driver. Hands on steering wheel? ◯ L ◯ R ◯ Both

◯ Passenger. Sitting in? ◯ Front ◯ Rear right ◯ Rear left

Seatbelt? ◯ Yes ◯ No Type: ◯ 3-point ◯ Lap

Did your seat have a headrest? ◯ Yes ◯ No

What happened?

◯ My vehicle struck another vehicle or object

◯ Another vehicle struck me

Which way were you facing at the time of impact?

◯ Straight ahead ◯ Left ◯ Right

Did you see the accident coming? ◯ Yes ◯ No

Did you brace for impact? ◯ Yes ◯ No

◯ Braced with hands ◯ Braced with feet

Where was the initial impact on your vehicle?

First Collision: ◯ Front ◯ Back ◯ Left ◯ Right

Second Collision: ◯ Front ◯ Back ◯ Left ◯ Right ◯ N/A

Did you strike anything in the vehicle at time of impact?

◯ Yes ◯ No

If yes, specify what part of your body struck what part of the vehicle:
I.E. HEAD, CHEST, CHIN, SHOULDER, RIGHT/LEFT KNEE

◯ Steering wheel _____

◯ Dashboard _____

◯ Wind shield _____

◯ Roof _____

◯ Left side door _____

◯ Right side door _____

◯ Left side window _____

◯ Right side window _____

◯ Other _____

Did the seat back bend / break? ◯ Yes ◯ No

Were you able to get out of the car and walk unaided?

◯ Yes ◯ No If no, why not:

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Did you go to hospital? ◯ Yes ◯ No

How did you get to hospital?

◯ Ambulance ◯ Police Car ◯ Private Transportation

Name of hospital?

When did you go to hospital? ◯ At time of accident ◯ Next day

Were you admitted to hospital? ◯ Yes ◯ No

If yes, for how long?

Name of Doctor at hospital?

What treatment were you given at hospital?

◯ None
◯ Placed in a cervical collar
◯ X-rayed
◯ Given stitches
◯ Bandaged
◯ Given pain medication
◯ Given instructions regarding concussions
◯ Given instructions regarding sprains and strains
◯ Physical therapy
◯ Instructed to call a specialist
◯ Instructed to call your physician
◯ Referred to this office for treatment
◯ Other _____

Have you lost time at work due to injuries? ◯ Yes ◯ No

How much time:

Have you been in a previous MVA? ◯ Yes ◯ No

Explain:

Have you seen a doctor as a result of this accident?

◯ Yes ◯ No Doctors name:

Do you have residual pain? ◯ Yes ◯ No

Explain:

Declaration

◯ I certify that the above information is correct and complete.

Date *DD/MM/YYYY*

Signature:

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