Willoughby
FAMILY CHIROPRACTIC

#130 8700 200Street
Langley, BC V2Y 0K1
Phone: 604-371-3939 Fax 604-371-0485
www.willoughbyfamilychiro.ca

Dr. Kelly Medeiros

New Patient Motor Vehicle Accident Form

Today's Date ___

Personal Information

Last Name: _____ First Name: _____

Mailing Address: _____City: _____ Postal Code: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Preferred communication for reminders (Please check one) Email ____ Phone ____

Date of Birth: _____ Age: _____ Care Card (PHN) #: _____

Marital Status: (circle one) S M D W CL Spouses Name: _____

Children's Names: _____

Pregnant: **O Yes** (If yes please notify the doctor) **O No**

Occupation: _____ City: _____

Emergency Contact: _____ Phone #: _____

How did you hear about our office?
Name: _____ Relationship:_____ Other: _____

Have you ever had X-Rays/ CT/ MRI? O Yes O No
If yes, Date(s): _____ Area(s) of Body:_____

Have you ever had Chiropractic Care before? O Yes O No When? _____

Accident Information

Date of Accident: _____ Type of Claim: O ICBC Claim O Other Claim

Claim #: _____ Claim Centre Address: _____ City_____ Province_____

Adjuster's Name: _____ Phone # : _____ Fax # :_____

Lawyer's Name: _____ Phone #:_____ Fax #:_____

Mailing Address: _____

Medical Doctor's Name: _____ Phone #:_____ Fax #:_____

Dr. Address:_____City:_____

Date of Last Dr. Appointment: _____Date of Last Physical: _____

Name: _____

Symptoms

How did you feel right after the impact/injury? _____
_____
_____

How do you feel today? Please compile a complete list including all of your symptoms/complaints: _____
_____
_____

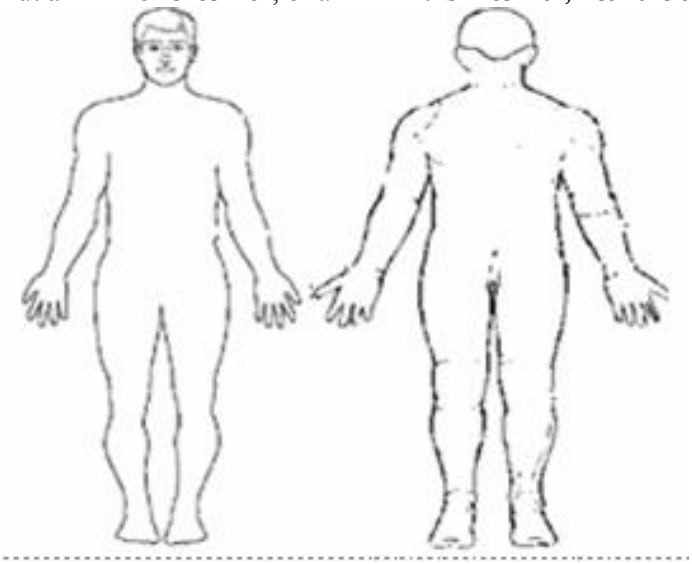
Your primary concern and expectations on recovery are: _____
_____

On the line provided, please mark where your pain level is today

_____

0 2 3 4 5 6 7 8 9 10
No Pain *Most Pain*

Please mark, on the following drawing, the areas where you feel pain.
Put an 'E' for **external**, or an 'I' if it is **internal**, near the area which you marked.



Are there any areas of numbness? O Yes O No Where? _____

Are there any areas of tingling? O Yes O No Where? _____

Has this symptom pattern ever occurred before? O Yes O No Where? _____

What makes your symptom worse? _____
_____

What makes your symptoms better? _____
_____

Injury Mechanics

Please give good detail on your position in the vehicle ie: feet on floor, sitting straight, hands on wheel, looking forward, etc.:

Before During impact / injury: _____

After impact / injury: _____

Name: _____

In this MVA were you the:	O Driver	O Passenger	O Pedestrian
Was this collision:	O Mild	O Moderate	O Severe
In this collision were you struck from:	O Front	O Back	O Right Side O Left Side
Were you:	O Stopped	O Travelling	O _____Km/Hr

Did your vehicle contact anything? _____

Estimated damage to your vehicle: _____

Type of seat belt:	O Shoulder/ Lap	O Lap	
Was seatbelt on at time of impact:	O Yes	O No	
Did you require hospitalization:	O Yes	O No	(If yes, describe ie. X-rays, stitches, etc.)

_____

The Bournmouth Questionnaire

The following scales have been designed to find out about your pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your pain?

0 2 3 4 5 6 7 8 9 10

No Pain *Worst pain possible*

2. Over the past week, how much has your pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

0 2 3 4 5 6 7 8 9 10

Interference *Interfered a lot*

3. Over the past week, how much has your pain interfered with your ability to take part in recreational, social and family activities?

0 2 3 4 5 6 7 8 9 10

Interference *Interfered a lot*

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

0 2 3 4 5 6 7 8 9 10

No anxiousness *Very anxious*

5. Over the past week, how depressed (down-in-the-dumps, sad, low spirits, pessimistic, unhappy) have you been feeling?

0 2 3 4 5 6 7 8 9 10

No depression *Very Depressed*

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your pain?

0 2 3 4 5 6 7 8 9 10

No Affect *Affected a lot*

7. Over the past week, how much have you been able to control (reduce/help) your pain on your own?

0 2 3 4 5 6 7 8 9 10

Total Control *No control at all*

Name: _____

PCS/ MTBI Symptom Check List

Please check all that apply.

Cognitive Problems

____ Attention or concentration (mind wanders; easily distracted; cannot keep focus)
____ Short-term memory loss, "forgetfulness", or trouble learning new things
____ Trouble remembering old things (remote memory)
____ Finding the right word when talking
____ Understanding what is said and/or what is read
____ Making decisions or solving problems
____ Planning or organization
____ Making more mistakes than usual or not catching your mistakes
____ Slower speed of thinking
____ Getting lost or disoriented (even in familiar places)
____ Trouble alternating attention or "juggling" several things at once
____ Disorganized or confused thinking

Physical Symptoms

____ Dizziness
____ Periods of "blacking out" or seizures
____ Problems with co-ordination of hands, feet, or legs (drop things more often, balance problems)
____ Stuttering or slurring
____ Change in the senses of smell or taste
____ Blurry or double vision
____ Ringing in the ears
____ Headaches
____ Fatigue
____ More sensitive to bright light and/or loud noises
____ Tingling or numbness in legs or arms

Emotional Symptoms

____ Feelings of sadness and depression
____ Crying spells or weepiness
____ Suicidal thoughts or intentions
____ Decreased or increased emotion (circle one)
____ Decreased or increased appetite (circle one)
____ Decreased interest in "fun" activities
____ Difficulties with sleeping (getting asleep or staying asleep)
____ Irritability/easily frustrated
____ Feelings of anxiety or fear

Name: _____

Pre Accident History

Have you had <u>any</u> prior history that has limited your job, personal daily activities, or your recreational abilities? Please list any limiting factors:

_____

_____

Have you ever suffered from (check all that apply):

Dizziness	O Yes	O No	Headaches	O Yes	O No
Heart Trouble	O Yes	O No	Asthma	O Yes	O No
Heartburn	O Yes	O No	Digestive Problems	O Yes	O No
Sinus Trouble	O Yes	O No	Menstrual Problems	O Yes	O No
Cancer	O Yes	O No	Depression	O Yes	O No
Numbness	O Yes	O No	Deafness	O Yes	O No
Ear Noises	O Yes	O No	High Blood Pressure	O Yes	O No
Bruise Easily	O Yes	O No	Menopausal	O Yes	O No

Please list any operations with their dates: _____

_____

_____

Please list any illnesses with their dates: _____

_____

_____

Any other hospitalizations? _____

Please list any family health conditions (ie: Arthiritis, Diabetes, Cancer, Heart, Disease) _____

_____

Other Accidents/Falls: _____

Emotional Traumas: _____

Current Medications Taken (for how long) _____

_____

_____

Have you ever been knocked unconscious? O Yes O No

Date: _____ For How Long? _____

Rate your quality of Health: O Excellent O Good O Ok O Poor O Terrible

Rate your quality of Sleep: O Excellent O Good O Ok O Poor O Terrible

List any sports, exercises and common activities you do:

_____

_____

_____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION *(11/08)*

Informed Consent to Chiropractic Treatment FORM-L

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment),
the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

_____	_____
Patient Signature (Legal Guardian)	**Witness Signature**
_____	_____
Name (please print)	**Name** (please print)

***OFFICE CANCELLATION POLICY:**

Please note there's a **full charge fee** for missed appointments or for those rescheduled/cancelled with less than 24 hours notice. Please remember, with less than 24 hours notice, it's difficult for others to come and fill your vacant appointment time.

X_____

Patient Signature acknowledging they have read and agreed to the above cancellation policy