

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

Occupation: \_\_\_\_\_ City: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

How did you hear about our office?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Other: \_\_\_\_\_

Have you ever had X-Rays/ CT/ MRI?  Yes  No

If yes, Date(s): \_\_\_\_\_ Area(s) of Body: \_\_\_\_\_

Have you ever had Chiropractic Care before?  Yes  No When? \_\_\_\_\_

### Accident Information

Date of Accident: \_\_\_\_\_ Type of Claim:  ICBC Claim  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? \_\_\_\_\_

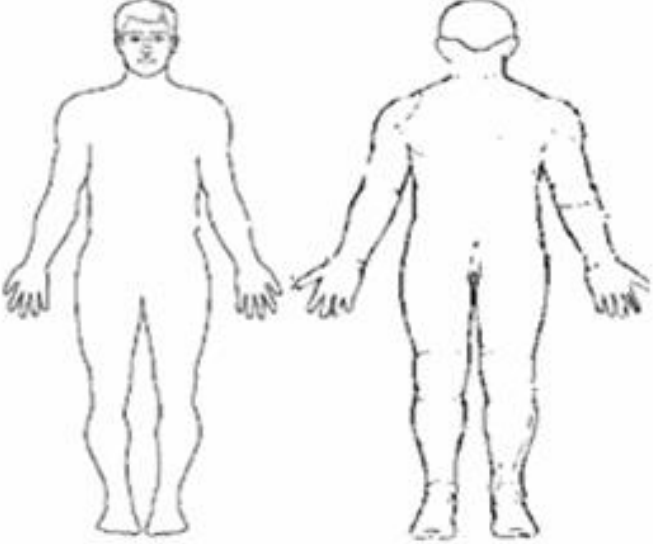
How do you feel today? Please compile a complete list including all of your symptoms/complaints: \_\_\_\_\_

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?  Yes  No Where? \_\_\_\_\_

Are there any areas of tingling?  Yes  No Where? \_\_\_\_\_

Has this symptom pattern ever occurred before?  Yes  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:                       Driver                                       Passenger                                       Pedestrian
- Was this collision:                                       Mild                                       Moderate                                       Severe
- In this collision were you struck from:                       Front                                       Back                                       Right Side     Left Side
- Were you:                                       Stopped                                       Travelling                                       \_\_\_\_\_ Km/Hr
- Did your vehicle contact anything? \_\_\_\_\_
- Estimated damage to your vehicle: \_\_\_\_\_
- Type of seat belt:                                       Shoulder/ Lap                                       Lap
- Was seatbelt on at time of impact:                       Yes                                       No
- Did you require hospitalization:                       Yes                                       No      (If yes, describe ie. X-rays, stitches, etc.)
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### **The Bournemouth 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*

## **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 any prior history that has limited your job, personal daily activities, or your recreational abilities?  
Please list any limiting factors:

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

Dizziness	<input type="radio"/> Yes	<input type="radio"/> No	Headaches	<input type="radio"/> Yes	<input type="radio"/> No
Heart Trouble	<input type="radio"/> Yes	<input type="radio"/> No	Asthma	<input type="radio"/> Yes	<input type="radio"/> No
Heartburn	<input type="radio"/> Yes	<input type="radio"/> No	Digestive Problems	<input type="radio"/> Yes	<input type="radio"/> No
Sinus Trouble	<input type="radio"/> Yes	<input type="radio"/> No	Menstrual Problems	<input type="radio"/> Yes	<input type="radio"/> No
Cancer	<input type="radio"/> Yes	<input type="radio"/> No	Depression	<input type="radio"/> Yes	<input type="radio"/> No
Numbness	<input type="radio"/> Yes	<input type="radio"/> No	Deafness	<input type="radio"/> Yes	<input type="radio"/> No
Ear Noises	<input type="radio"/> Yes	<input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes	<input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes	<input type="radio"/> No	Menopausal	<input type="radio"/> Yes	<input type="radio"/> No

Please list any operations with their dates: \_\_\_\_\_

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Please list any illnesses with their dates: \_\_\_\_\_

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Any other hospitalizations? \_\_\_\_\_

Please list any family health conditions (ie: Arthritis, Diabetes, Cancer, Heart, Disease) \_\_\_\_\_

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Other Accidents/Falls: \_\_\_\_\_

Emotional Traumas: \_\_\_\_\_

Current Medications Taken (for how long) \_\_\_\_\_

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Have you ever been knocked unconscious?  Yes  No

Date: \_\_\_\_\_ For How Long? \_\_\_\_\_

Rate your quality of Health:  Excellent  Good  Ok  Poor  Terrible

Rate your quality of Sleep:  Excellent  Good  Ok  Poor  Terrible

List any sports, exercises and common activities you do:

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**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\_\_\_\_\_.**

_____ <b>Patient Signature (Legal Guardian)</b>	_____ <b>Witness Signature</b>
_____ <b>Name</b> (please print)	_____ <b>Name</b> (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