Willoughby
FAMILY CHIROPRACTIC

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Dr. Spooner & Dr. McManus

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: _____
_____
_____

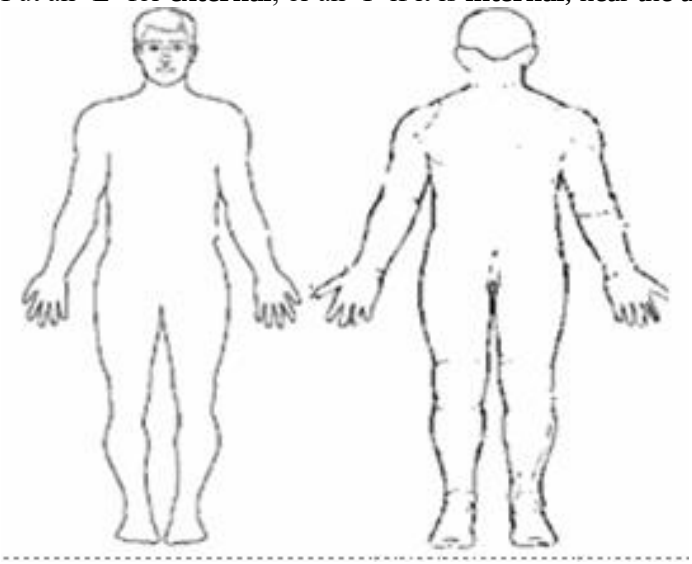
Your primary concern and expectations on recovery are: _____
_____

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

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

  Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

  The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

  Alternatives Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____

Name (Please Print)

_____ Date: _____ 20____

Signature of patient (or legal guardian)

_____ Date: _____20____

Signature of Chiropractor

***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