Motor Vehicle Insurance Intake - North Ajax Rehab and Sports Injury Clinic

CLIENT INFORMATION:

Name: _____ Age: _____ Birth date: Month _____ Day _____Year_____

Address: _____ I identify my gender as: _____

City of: _____ Postal Code: _____

Phone: Home ( ) _____ Cell: ( ) _____ Work: ( ) _____Ext.#:_____

E- Mail: _____

In Case of Emergency call: _____ Phone: ( ) _____ Relationship to client: _____

Family doctor: _____ Referral Source: ☐ Family Physician ☐ Specialist/Surgeon ☐ Family/Friends ☐ Yellow Pages ☐ Other: _____

INSURANCE COVERAGE: Date of accident: _____

Name of MVA Insurance Company: _____

Address: _____City:_____ Postal Code:_____

Name of Adjuster: _____Adjuster Phone: _____Fax:_____

Policy Holder: _____Policy Number:_____

Claim Number: _____ Relationship to Policy Holder: _____

Have you received treatment for this injury? ☐ Yes ☐ No If yes, where?_____

Extended Health coverage? ☐ Yes ☐ No

If Yes: 1. My own plan is with: _____ Plan #: _____ Policy #: _____

2. My spouse's plan is with: _____ Plan #: _____ Policy #: _____

To assist us with invoicing:

1. What is the maximum coverage available on you plan(s): _____ (Physiotherapy)
   _____ (Massage Therapy)
   _____ (Acupuncture)
2. What is the calendar year for your plan(s)? _____
3. Have you already used some of your coverage this year? _____

Motor Vehicle Accident:

You were ☐ the driver ☐ a passenger ☐ on a motorcycle ☐ riding a bicycle ☐ a pedestrian

You were seated ☐ driver's seat ☐ front passenger ☐ rear left ☐ rear right ☐ middle

Your vehicle was impacted ☐ front ☐ rear ☐ driver's side ☐ passenger' side ☐ not sure

Wearing a seatbelt? ☐ Yes ☐ No Headrest? ☐ Yes ☐ No Weather conditions? _____

Did you hit your head? ☐ Yes ☐ No Did you lose consciousness during or after the impact? ☐ Yes ☐ No

Was your vehicle drivable post-accident? ☐ Yes ☐ No Were you able to get out/walk around unassisted? ☐ Yes ☐ No

Have the injuries you've sustained during this accident affected your ☐ work ☐ activity/sports? ☐ Home life? ☐ Sleep?

Prior collisions? ☐ Yes ☐ No

Please list your prior injuries, the date(s) of the collisions, and your percent recovery before current accident:

_____

_____

Major injuries or surgeries (and timeframes)

_____

_____

Current medications:_____

_____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No

If yes, what treatment are you receiving? _____

Symptoms (Check all that apply)	Before Collision No	Before Collision Yes	Immediately following No	Immediately following Yes	Currently Experience No	Currently Experience Yes	Rate Your Symptoms
Headaches	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Neck pain and/or stiffness	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Shoulder or arm pain and/or stiffness	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Back Pain/stiffness – upper back	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Back Pain/stiffness – mid - back	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Back Pain/stiffness – lower back	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Hip or Leg pain/stiffness	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Pain – other areas? _____	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Jaw, tooth or ear pain	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Arm or hand weakness and/or tingling	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Loss of co-ordination	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Dizziness	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Difficulty swallowing and/or speaking	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Nausea and/or vomiting	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Vision affected?	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Numbness around your mouth?	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Ringing in the ears (tinnitus), hearing loss	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Trouble concentrating and/or memory loss	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable
Sleep and/or personality changes	☐	☐	☐	☐	☐	☐	None 1 2 3 4 5 6 7 8 9 Unbearable

Past Symptoms:

Muscle, Skeletal and Nervous Systems

- ☐ Arm/hand weakness or tingling
- ☐ Leg/ ankle/foot weakness or tingling
- ☐ Head trauma or concussion
- ☐ Light headedness / fatigue
- ☐ Epilepsy /seizures
- ☐ Degenerating Discs
- ☐ Osteo or rheumatoid arthritis
- ☐ Osteoporosis or bone disease
- ☐ Tendonitis, bursitis
- ☐ Fractures / pins, wires, plates
- ☐ Carpal tunnel syndrome
- ☐ Loss of sensation

Skin and Immune Systems

- ☐ Open sores, cuts or warts
- ☐ Contagious skin disease
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ HIV
- ☐ Cancer
- ☐ Allergies _____

Heart and Circulatory Systems

- ☐ High or low blood pressure
- ☐ Congestive heart failure
- ☐ Heart disease / attack or stroke (CVA)
- ☐ Chest pain or angina
- ☐ Pacemaker or similar device
- ☐ Varicose veins or phlebitis
- ☐ Cold hands and feet or swelling
- ☐ Diabetes
- ☐ Poor healing / bruise easily
- ☐ Haemophilia

Breathing System

- ☐ Asthma
- ☐ Bronchitis or emphysema
- ☐ Shortness of breath
- ☐ Frequent colds or sinus
- ☐ Chronic cough / smoking

Women

- ☐ Pregnant, due: _____
- ☐ Gynaecological conditions

Digestive System

- ☐ Nausea or vomiting
- ☐ Constipation
- ☐ Rapid weight loss
- ☐ Appetite changes
- ☐ Diarrhea
- ☐ Irritable Bowel
- ☐ Ulcers
- ☐ Gall Bladder problems

Life Questions

- ☐ I exercise regularly
- ☐ I feel good about life
- ☐ I have good sleeping patterns
- ☐ I have poor energy levels
- ☐ I suffer from too much stress

Please rate your overall health

1 2 3 4 5 6 7 8 9 10

Poor Moderate Excellent

Today's Date: _____ Signature: _____