Motor Vehicle Accident QUESTIONNAIRE

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The person who signs this form must be over the age of 16. If you are completing this form on behalf of someone, what is your relationship to the injured person?

Parent/Guardian/Friend/Other (please specify).....

ICBC Claim number:……...

Lawyer's name:……

Law Firm name:……

Pre-Medical Questionnaire

About You

Full Name:	
Date of Birth:	
Right or Left Handed:	

Past Medical History

Have you had any previous accidents, injuries or health problems? Please list them here, including when they occurred, what treatment was needed, and whether they still affect you now. If you need more space, please continue over the page.

Previous Accidents? When did it happen? What injuries did you have? Did you make a full recovery? How long did your recovery take?	
Physical Health? Are you normally in good health? Have you had any serious illnesses? Have you had neck, back or shoulder problems in the past?	
Mental Health? Have you had any problems with anxiety or depression?	
Current Medication? What treatments do you take?	

The Accident

This part of the form is for people who were in a vehicle at the time of the accident. If that doesn't apply to you, please describe your accident on the back of this page.

Date of Accident:	
Approx Time of Accident:	
Your Vehicle: What kind of vehicle were you in?	
Your Position: Driver, front or rear seat passenger?	
Seat Belt: Were you wearing a seatbelt?	
Head Rest: Was a headrest fitted?	
Air Bag: Was there one? Did it deploy?	
Your Vehicle's Movement: Moving, stationary or turning?	
Your Vehicle's Location: 4-way stop, traffic lights etc.	
The Impact: Briefly describe how the accident happened, the speed and force of it, and which part of your vehicle was hit.	
Expecting the accident: Were you expecting to be hit? Did you brace for impact?	
Damage to Your Vehicle: How badly damaged was it?	
Thrown at Impact: How were you thrown at impact?	
Get Out of Vehicle: Did you need any help to get out?	

Initial Injuries and Symptoms

Please describe the injuries or symptoms you noticed **at the time of the accident**. Include both physical and any psychological symptoms you experienced. If you need more space, please continue on the other side of this page. An example has been completed to guide you.

Injury or Symptom: Briefly describe what you felt.	**Initial Severity:** How bad was it at first? Mild, Moderate, Severe	**Current Status:** How bad is it now? Mild, Moderate, Severe If it has resolved, how long after the accident did it resolve?
Example: Neck Pain	Moderate	Cleared up after 3 months.

Later Symptoms

Please describe any symptoms that came on **some time after the accident**.

Symptom: Briefly describe what you felt.	**Delay:** How long after the accident did it start?	**Initial Severity:** How bad was it at first? Mild, Moderate, Severe	**Current Status:** How bad is it now? Mild, Moderate, Severe If it has resolved, how long did it take to resolve?
Example: Back Pain	3 days	Moderate	Still stiff and sore.

Initial Treatment

What treatment did you receive **on the day of the accident**?

Treatment at the Scene:

Did you need any? Yes/No	
Who treated you? e.g. paramedic, passer-by	
What was the treatment? e.g. dressings, painkillers	

Travel from the Scene:

Where did you go next? e.g. home, work, ER	
How did you travel there? e.g. drove, got a lift, by ambulance	

Other Treatment on the day of the accident:

Did you have any? Yes/No	
Where did you have it? e.g. ER, GP, work, home	
What was the treatment? e.g. dressings, painkillers	
Did you have any tests? e.g. x-ray of neck	
What were the results? e.g. normal, fracture	

Later Treatment

What other treatment have you received since the accident?

Treatment: What treatment have you had? How many visits or sessions? e.g. GP, physiotherapy	**Timing:** How long after the accident did you start the treatment?	**Outcome:** How successful has it been? e.g. physio improved neck pain e.g. GP gave sick note and painkillers
Example: Attended GP 3 times	3 days, 2 weeks, and 4 weeks	Got sick note, painkillers and physio referral.

Effect on Work

How has the accident affected your work?
If you have more than one job, please give details on the back of this page.

What is your job? e.g. taxi driver	
Normal hours per week: e.g. 40 hours	
How much time off? e.g. none, 2 weeks, still off?	
Light Duties? For how long? Duties still light?	
Reduced Hours? For how long? Hours still reduced?	
Lost Job? Why? What happened?	
Changed Job? Why? What do you do now?	

Effect on Travel

Have you had any problems as a driver or a passenger?

As a Driver:

Any pain or discomfort? Yes/No How severe has it been? How long has it lasted?	
Any anxiety? Yes/No How severe has it been? How long has it lasted?	

As a Passenger:

Any pain or discomfort? Yes/No How severe has it been? How long has it lasted?	
Any anxiety? Yes/No How severe has it been? How long has it lasted?	

Home Situation

Who lives with you at home?

Adults: e.g. partner e.g. parents	
Children: How many? What are their ages?	

Effect on Home Life

How has the accident affected your home life?
If there have been any problems, please list them below.

Problem: Briefly describe the problem. e.g. housework, shopping, sport. e.g. missed out on holiday (include destination) or special event.	**Current Status:** How bad was it to start with? How bad is it now? If it has resolved, how long did it take to resolve?
Example: Could not do shopping because of shoulder pain. Husband had to carry the bags.	It settled after 3 weeks, but I still have problems with heavy items.

Other Information or Comments

Please use this space to add any other information or comments you wish:

Final Declaration

Thank you very much for completing this questionnaire. The information will be used as part of the medical report that the doctor writes about you, so it is important that it is as detailed and accurate as possible. Please sign and date the declaration:

I confirm that the information given in this questionnaire is a true and accurate description of the circumstances and injuries of my accident.

Signed **Dated**