INSURANCE FORM - MVA

PATIENT NUMBER: _____

Name: _____

Home Telephone: _____ Business Telephone: _____

Insurance Company: _____

Address: _____ Postal Code: _____

Date of Accident: _____ Claim Number: _____

Agent: _____ Telephone: _____

Adjustor: _____ Telephone: _____

Address: _____ Postal Code: _____

MD/Hospital: _____ X-rays: YES NO

Did you require to be taken by an ambulance to a hospital: YES NO

Did you receive medical attention: YES NO

If required to stay in the hospital, how long did you stay: _____

HISTORY OF ACCIDENT: _____

_____

_____

_____

_____

_____

IF FOR ANY REASON THE INSURANCE WILL NOT ACCEPT OR DISCONTINUE YOUR CLAIM, YOU ARE RESPONSIBLE FOR ALL CHARGES.

_____ _____

Signature Date

Patient was Ò Driver Ò Passenger Front/Back Ò Driven by _____
Patient's Vehicle _____ Ò Stopped Estimated speed _____ kph
Time Ò Day Ò Night Ò Dawn Ò Dusk
Road condition Ò Dry Ò Damp Ò Wet Ò Icy
Head rest Ò None Ò Integral Ò Adjusted in _____ Position
Seatbelt Ò None Ò Not wearing Ò Wearing
Shoulder harness Ò None Ò Not Wearing Ò Wearing
Head position Ò Ahead Ò Right Ò Left
Hands Ò One on wheel Ò Two on wheel
Brakes on Ò Yes Ò No
Transmission Ò Automatic Ò Manual
Aware of collision Ò Yes Ò No
Felt body go Ò Forward then back Ò Back then forward

Describe how you felt at the time immediately after the accident (faint, numb, instant pain in the neck, mid back or low back) _____
_____
_____

Describe any cuts and bruises (location) you sustained _____
_____

Could you move all parts of your body? If no, specify_____
Could you walk? Y N
Were you conscious at all times? Y N

Describe how you felt that evening _____
_____

State specifically how you felt the day after the accident _____
_____

Where were you examined first? _____
When _____

What was done? (X-Rays, medication, examination, etc) _____
_____

What were you told or given? _____
_____

Did you see any others doctors? If so, who and when _____

Did you stay in the hospital? If so, where and how long? _____
_____

If you have been off work, what days were you off? _____

VICTORIA CHIROPRACTIC CLINIC
1820 E. VICTORIA AVE. THUNDER BAY, ON P7C 1E2
(807)623-6118 FAX (807)622-8667

Date	Patient #

PERSONAL HISTORY

Name:_____ Address:_____
City:_____ Province:_____ Postal Code:_____
Home Phone#:_____ Birth date:_____ Age:_____ Sex: ☐ M ☐ F
Cell #:_____ Extended Health Coverage: _____
Business/Employer: _____ Type of Work:_____
Business Phone #:_____ Circle One: Married Single Widowed Divorced Separated Other No. Of Children:_____
Name of Emergency Contact:_____ Phone #:_____ Relationship:_____
Are you interested in receiving ☐ email reminders ? _____
Who may we thank for referring you to this office: _____

CURRENT HEALTH CONDITION

Current Complaint:_____
Other Doctors Seen for this Condition: ☐ Yes ☐ No If yes, who?_____
Type of Treatment: _____ Results:_____
When did this condition begin:_____ Has this condition occurred before? ☐ Yes ☐ No
Date of Accident:_____ Time of Accident:_____
What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Down ☐ Cold ☐ Dampness ☐ Other_____
What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other_____
Is it: ☐ Getting Worse ☐ Constant ☐ Comes/Goes ☐ Getting Better
Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles
☐ Numb ☐ Burning ☐ Constant ☐ Intermittent
Please describe how it feels when this pain is at its worst:_____
Place an **X** on the grade indicating the severity of your pain: LEAST 1 2 3 4 5 6 7 8 9 10 WORST
Compare this problem at its worst and a time when you feel great. How does this problem at its worse interfere with:
Your ability to work?_____
Your ability to enjoy your family and social time?_____
Your ability to enjoy your hobbies or sports?_____
At its worst, how old does it make you feel?_____
If you don't get this problem corrected, do you think it will get worse over the next 5 years? ☐ YES ☐ NO
Drugs you now take: ☐ Nerve Pills ☐ Painkillers/Muscle Relaxers ☐ Blood Pressure Medicine
☐ Insulin ☐ Other:_____
Do you suffer from any condition other than that for which you are now consulting us?_____
_____
On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem:_____
Have your had X-Rays taken in the last six months? ☐ Yes ☐ No If yes, where?_____

PAST HEALTH HISTORY

Please check or describe:
Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery
☐ Broken Bones ☐ Other_____
Previous: ☐ Childhood Traumas_____ ☐ Sports Injuries_____
☐ Motor Vehicle Accidents_____ ☐ Work Injuries_____
Hospitalization (other than above):_____
Previous Chiropractic Care: ☐ None ☐ Doctor's name and approximate date of last visit:_____

FAMILY HEALTH HISTORY

Have your children ever had a spinal check-up? ☐ No ☐ Yes Where and when?_____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following diseases you have had:

- ☐ Pneumonia
- ☐ Mumps
- ☐ Influenza
- ☐ Rheumatic Fever
- ☐ Small Pox
- ☐ Pleurisy
- ☐ Polio
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Whooping Cough
- ☐ Cancer
- ☐ Mental Disorder
- ☐ Anemia
- ☐ Heart Disease
- ☐ Lumbago
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema

Check any of the following you have had in the past six months:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Gas/Bloating After Meals
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Black/Bloody Stool
- ☐ Arm Pain
- ☐ Colitis
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction

GENOTI-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

FEMALES ONLY

When was your last period?_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ White Sugar
- ☐ Cigarettes

PERSONAL SATISFACTION WITH DIET

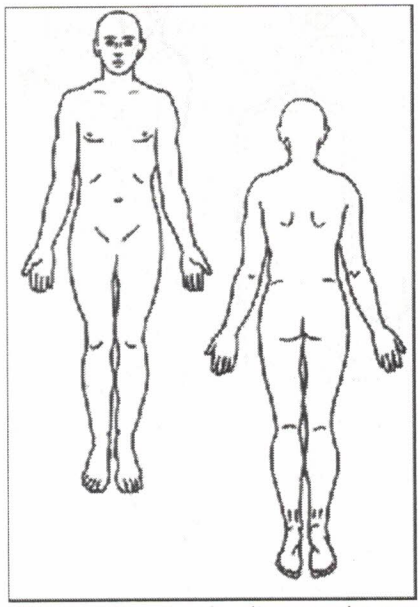
- ☐ Highly Satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Highly Dissatisfied

DO YOU EXERCISE REGULARLY?

☐ Yes ☐ No

LIFESTYLE STRESS LEVELS

- ☐ High
- ☐ Moderate
- ☐ Very Little



Please outline on the diagram the area of your discomfort and any radiation of pain.

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.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

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