CEDAR HILLS
CHIROPRACTIC

DR. SCOTT BANMAN, D.C
DR. BRIAN CERVO, D.C

Auto Injury Form

Name _____	**ICBC Claim #** _____
ICBC Adjuster_____	Adjuster's Phone #_____
Lawyer _____	Lawyer's Phone # _____

1) Accident date _____ Approximate time _____
2) Were you DRIVER or PASSENGER which seat_____
3) Wearing seatbelt YES / NO Headrest YES / NO Airbag(s) inflate YES / NO
4) Model of Vehicle _____
5) Model of other vehicle _____
6) Upon impact your car was STOPPED MOVING TURNING (R / L)
7) Where was your car struck SIDE REAR FRONT
8) Was there more than one impact Explain _____
_____

1. Did you see the accident coming YES / NO
2. Was your head turned or your body in an unusual position at impact Explain _____
_____
3. Did your head hit STEERING WHEEL SIDE WINDOW WINDSHEILD ROOF
4. Were you CONFUSED DISORIENTATED HEAD PAIN
5. Describe if you were unconscious at any point _____
6. Did anyone/anything inside the vehicle hit you _____
7. Describe any areas that hurt immediately _____
_____
8. Were you able to get out of the car and walk? YES / NO

1) Was an ambulance called for you YES / NO
2) Did you go to the hospital YES / NO
3) If so, did you get X-RAYS/SCAN_____ MEDICATION_____
4) How long were you there _____ Name of hospital _____
5) Did you see FAMILY MD WALK-IN MD Name_____
When_____
6) Describe if your discomfort worsened over the next few days _____
_____

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Since the accident what are the main complaints you are now experiencing _____

_____

_____

_____

Are you experiencing any complaints of:

☐	Difficulty with: SHORT-TERM MEMORY FOCUS CONCENTRATION FATIGUE		
☐	MOOD SWINGS IRRITABILITY DEPRESSION ANXIETY		
☐	*ARMS*: PAIN NUMBNESS TINGLING WEAKNESS		
☐	*LEGS*: PAIN NUMBNESS TINGLING WEAKNESS		
☐	Difficulty swallowing	☐	Chest pain or difficulty breathing
☐	Difficulty controlling BOWEL / BLADDER	☐	Insomnia
☐	Headaches	☐	Jaw pain
☐	Dizziness	☐	Ringing in ears

Please list any other problems of significance _____

_____

_____

Were any of these complaints present before the accident? _____

_____

If so, were any of these complaints worse after the accident?
Describe changes _____

_____

Your occupation _____ P/T F/T Other _____

Have you been off work since the accident? YES / NO

Have you missed any work as a result of the accident? _____

_____

_____
Name

_____
Signature

_____
Date