VEHICLE ACCIDENT REPORT

Please fill out the following information to the best of your knowledge.
It is understood that you may not recall all relevant information at this time.

Name_____

Date of Accident: Month_____ Day _____ Year_____

Time of Accident: _____:_____ (AM/PM)

BC Care Card: _____
(BC care card numbers are required to bill to ICBC)

Phone Number: _____

Claim #:_____

Adjuster Name_____ Adjuster Phone Number_____

Lawyer Name _____ Lawyer Phone Number _____

Lawyer's Firm _____

It is imperative that this form be filled our completely to protect your rights of compensation. This form may be used in the determination of insurance benefits and/or litigation for compensation.

*****PLEASE RETURN THIS FORM TO THE OFFICE AS SOON AS POSSIBLE*****

Were you: A) Driver
B) Passenger (Front)
C) Passenger (Rear)
D) Pedestrian

Were you wearing a seatbelt? Yes_____ No_____

Type of vehicle: A) Auto
B) Truck
C) Van
D) Motorcycle
E) Motor home
F) Bicycle

How did the accident occur: A) Struck by another vehicle
B) Struck another vehicle
C) Struck a stationary object
D) Other

Where was your vehicle hit: A) Front
B) Rear
C) Right Side
D) Left Side
E) Right Front
F) Left Front
G) Right Rear
H) Left Rear

Where was the other vehicle hit: A) Front
B) Rear
C) Right Side
D) Left Side
E) Right Front
F) Left Front
G) Right Rear
H) Left Rear

Your approximate speed _____KMH

Other vehicle approximate speed _____KMH

What occurred at the moment of impact? (Circle as many as apply)

A) Tensed body for impact
B) Neck whipped forward and back
C) Spine torqued and twisted
D) Thrown over sear
E) Thrown from vehicle
F) Pinned in vehicle
G) Thrown from side to side
H) Cut and bruised

Did you strike your : (Circle as many as apply)

A) **Head** Against the: Dashboard ----- Windshield----Steering Wheel
Right Door----Left Door----Seat Frame---Unknown Object

B) **Shoulder** (left/right) Against the: Dashboard ----- Windshield----Steering Wheel
Right Door----Left Door----Seat Frame---Unknown Object

C) **Arm** (left/right) Against the: Dashboard ----- Windshield----Steering Wheel
Right Door----Left Door----Seat Frame---Unknown Object

D) **Elbow** (left/right) Against the: Dashboard ----- Windshield----Steering Wheel
Right Door----Left Door----Seat Frame---Unknown Object

E) **Wrist** (left/right) Against the: Dashboard ----- Windshield----Steering Wheel
Right Door----Left Door----Seat Frame---Unknown Object

F) **Hip** (left/right) Against the: Dashboard ----- Windshield----Steering Wheel
Right Door----Left Door----Seat Frame---Unknown Object

G) **Knee** (left/right) Against the: Dashboard ----- Windshield----Steering Wheel
Right Door----Left Door----Seat Frame---Unknown Object

H) **Ankle** (left/right) Against the: Dashboard ----- Windshield----Steering Wheel
Right Door----Left Door----Seat Frame---Unknown Object

Were you rendered unconscious ? Yes No

Did you receive medical attention at the scene of the accident? Yes No

Where did you go immediately following the accident?
A) Hospital B) Home C) Personal Doctor D) To this office E) Resumed activities

Were you: A) Shaken B) Disoriented

Did you have any physical complaints **before** the accident? Yes No
If Yes please
describe:_____
_____
_____

In your own words, please describe the
accident_____
_____
_____
_____

How did you feel immediately after the
accident?_____
_____
_____

General Symptoms: (Circle as many as apply)
A) Nervousness B) Irritability C) Fatigue D)Depression E)Loss of Sleep
F) Tension G) PMS H) Jaw Pain

Head: (Circle as many as apply)
A) Headache 1---Mild 2---Moderate 3---Severe
How often: (1 2 3 4 5 6) Per Day / Week / Month
Are they: 1---Sharp 2---Dull 3---Constant 4---Intermittent

Where is the headache located: 1) Back of Head 2) Forehead 3) Temples
4)Right Side 5) Left Side 6) Behind Eyes

B) Light headed C) Memory Loss D) Fainting E) Blurred Vision F) Double Vision

G) Sensitivity to Light H) Loss of Balance I) Hearing Loss J) Ringing Ears

Neck: (Circle as many as apply)

A) Pain 1---Left Side 2---Right Side 3---Both

Pain level 1---Mild 2---Moderate 3---Severe

Pain increased by: 1) Forward Movement 2) Backward Movement

3) Rotate Head Left 4) Rotate Head Right

5) Bend Neck Left 6) Bend Neck Right

B) Stiffness C) Muscle Spasm D) Grinding/ Grating Sounds

Shoulder: (Circle as many as apply)

A) Pain in Joint	1) Left	2) Right	3) Both
B) Pain Across Shoulder	1) Left	2) Right	3) Both
C) Limitation of Movement	1) Left	2) Right	3) Both
D) Tension	1) Left	2) Right	3) Both

Arms: (Circle as many as apply)

A) Pain in Upper Arm	1) Left	2) Right	3) Both
B) Pain in Elbow	1) Left	2) Right	3) Both
C) Pain in Forearm	1) Left	2) Right	3) Both
D) Pins and Needles (Arm)	1) Left	2) Right	3) Both
E) Pins and Needles (Forearm)	1) Left	2) Right	3) Both
F) Numbness in Arm	1) Left	2) Right	3) Both
G) Numbness in Forearms	1) Left	2) Right	3) Both

Hands: (Circle as many as apply)

A) Pain in Wrist	1) Left	2) Right	3) Both
B) Pain in Hand	1) Left	2) Right	3) Both
C) Pins and Needles (Hand)	1) Left	2) Right	3) Both
D) Numbness (Hand)	1) Left	2) Right	3) Both

Mid Back: (Circle as many as apply)

A) Pain 1) Left 2) Right 3) Both

Pain level 1---Mild 2---Moderate 3---Severe

Pain type 1---Sharp/Stabbing 2---Dull Ache

B) Muscle Spasm 1) Left 2) Right 3) Both

Chest: (Circle as many as apply)

A) Deep Chest Pain 1) Left 2) Right 3) Both

Pain level 1---Mild 2---Moderate 3---Severe

B) Pain around ribs 1) Left 2) Right 3) Both

C) Shortness of Breath

D) Irregular Heart beat

Abdominal Symptoms: (Circle as many as apply)

A) Pain 1---Mild 2---Moderate 3) Severe
B) Nervous Stomach
C) Nausea
D) Gas
E) Constipation
F) Diarrhea
G) Heartburn
H) Indigestion
I) Loss of Appetite

Low Back: (Circle as many as apply)

A) Upper Lumbar Pain 1) Left 2) Right 3) Both
Pain level 1---Mild 2---Moderate 3---Severe
B) Lower Lumbar Pain 1) Left 2) Right 3) Both
Pain level 1---Mild 2---Moderate 3---Severe
C) Sacro-iliac Pain 1) Left 2) Right 3) Both
Pain level 1---Mild 2---Moderate 3---Severe
D) Muscle Spasm 1) Left 2) Right 3) Both

Hips and Legs: (Circle as many as apply)

A) Pain in Buttocks 1) Left 2) Right 3) Both
Pain level 1---Mild 2---Moderate 3---Severe
B) Pain in Hip Joint 1) Left 2) Right 3) Both
Pain level 1---Mild 2---Moderate 3---Severe
C) Pain Down Leg 1) Left 2) Right 3) Both
Pain level 1---Mild 2---Moderate 3---Severe
Location of Pain 1) Front 2) Back 3) Side
Pain Radiates to 1) Knee 2) Calf 3) Foot
D) Numbness Down Leg 1) Left 2) Right 3) Both
Location of Pain 1) Front 2) Back 3) Side
E) Pins and Needles (Leg)
Location of Pain 1) Front 2) Back 3) Side
F) Knee Pain 1) Left 2) Right 3) Both
G) Leg Cramps 1) Left 2) Right 3) Both

Feet: (Circle as many as apply)

A) Ankle Pain 1) Left 2) Right 3) Both
B) Swollen Ankle 1) Left 2) Right 3) Both
C) Foot Pain 1) Left 2) Right 3) Both
D) Numbness of Feet 1) Left 2) Right 3) Both
E) Swollen Feet 1) Left 2) Right 3) Both
F) Cramps 1) Left 2) Right 3) Both

Did you see the accident coming? Yes / No

Was your headrest positioned? Yes / No

How many passengers were in the vehicle? _____

What was the other vehicle in the collision? _____

Upon impact, which way was your head turned? _____

Which way were you thrown? _____

Estimated damage to your vehicle? _____

Were you able to get out and walk? Yes / No

Were you able to move all body parts? Yes / No

Have you had an X-RAY/ CT Scan/ MRI of the area in pain before _____ or after_____ the accident?

If you went to a hospital, who was the attending Physician? _____

What was done? Examination _____ XRAY_____ Medication____ CT Scan _____

Where you confined to bed____ wheelchair____ other_____ and for how long?_____

Have you consulted another physician since the accident? _____

Name of Physician _____

List dates of any previous motor vehicle accidents:_____

List dates you missed work as a result of the accident:
_____
_____

Describe your duties at work
_____
_____
_____

Are you able to work now? Yes____ No_____ Partially _____

What duties are you **unable** to perform
At
work:_____
_____
At
home:_____
_____

What discomfort did you experience
the first
evening:_____
_____
the next day:
_____
_____
Since the accident:
_____
_____

AUTHORIZATION OF PATIENT OR GUARDIAN

I _____ hereby authorize the release to the Insurance Corporation of British Columbia any medical information relating to my injuries, as a result of a motor vehicle accident on _____.
This authorization includes future progress reports as required.

_____ _____
SIGNATURE DATE