A Total Approach to Health and Wellness

MVA INFORMATION BOOKLET

BILLING INFORMATION

Patient Name: _____

Date of Injury: _____

Time of Injury: _____

City and Street where accident occurred: _____

_____

What is the estimated damage to your vehicle? $ _____

Do you have private medical insurance coverage? ☐ Yes ☐ No

If yes: Name, address, phone # _____

_____

MOTOR VEHICLE INSURANCE INFORMATION

Name of insurance company? _____

Address: _____

Policy # _____ Phone # _____

Have your reported this injury to your car insurance company? ☐ Yes ☐ No

If yes, what is your claim #? _____

What is the claims adjuster's name? _____

Did the police come to the accident scene and make a report? ☐ Yes ☐ No

Is an attorney representing you? ☐ Yes ☐ No

Name, address and phone # of attorney: _____

_____

We will help you as much as we can to access the insurance money you are entitled to; but if for any reason your claim is denied the <u>fees for the services provided in this clinic are your responsibility and are due at the time the services are provided</u>.

_____ _____

Date Signature

LIST ALL DOCTORS, TESTS AND TREATMENTS SINCE YOUR INJURY

(Start with the first doctor/office/hospital you saw after your injury and check all that apply.)

1. Name of hospital/doctor/therapist/centre: _____

   Address: _____ Date: _____

   Indicate what was done:

☐ Exam consultation	☐ Medications prescribed
☐ X-ray of neck	☐ Neck Collar
☐ X-ray of low back	☐ Spinal manipulation/adjustments
☐ Other X-rays	☐ Muscle massage/myotherapy
☐ MRI/CT scan	☐ Low back brace
☐ Other diagnostic test	☐ Heat packs
☐ Rehabilitation	☐ Cold/ice packs
☐ Physical therapy	☐ Ultrasound
☐ Exercises recommended	☐ Other

   Indicate if treatment: ☐ Made condition worse ☐ Did not help ☐ Helped

   Explain: _____

2. Name of hospital/doctor/therapist/centre: _____

   Address: _____ Date: _____

   Indicate what was done:

☐ Exam consultation	☐ Medications prescribed
☐ X-ray of neck	☐ Neck Collar
☐ X-ray of low back	☐ Spinal manipulation/adjustments
☐ Other X-rays	☐ Muscle massage/myotherapy
☐ MRI/CT scan	☐ Low back brace
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☐ Rehabilitation	☐ Cold/ice packs
☐ Physical therapy	☐ Ultrasound
☐ Exercises recommended	☐ Other

   Indicate if treatment: ☐ Made condition worse ☐ Did not help ☐ Helped

   Explain: _____

3. Name of hospital/doctor/therapist/centre: _____

Address: _____ Date: _____

Indicate what was done:

☐ Exam consultation	☐ Medications prescribed
☐ X-ray of neck	☐ Neck Collar
☐ X-ray of low back	☐ Spinal manipulation/adjustments
☐ Other X-rays	☐ Muscle massage/myotherapy
☐ MRI/CT scan	☐ Low back brace
☐ Other diagnostic test	☐ Heat packs
☐ Rehabilitation	☐ Cold/ice packs
☐ Physical therapy	☐ Ultrasound
☐ Exercises recommended	☐ Other

Indicate if treatment: ☐ Made condition worse ☐ Did not help ☐ Helped

Explain: _____

Please check the following boxes that correspond to any symptoms that you have had recently since your neck or head injury.

☐ Headaches	☐ Loss of coordination
☐ Reduced drive/motivation	☐ Poor memory
☐ Difficulty finishing tasks	☐ Sleep disorders
☐ Abnormal levels of anxiety	☐ Reduced tolerance to alcohol
☐ More assertive	☐ Forgetfulness
☐ Anger outbursts	☐ Depression
☐ Fatigue	☐ Absence of ability to anticipate
☐ Inflexibility	☐ Impaired sexual function
☐ Language difficulty	☐ Impaired judgment
☐ Need assistance to remember home and/or work activities	☐ Dizziness/lightheadedness
☐ Blurry vision	☐ Loss of balance
☐ Difficulty handling multiple tasks	☐ Irritability
☐ Personality change	☐ Hand tremors
☐ Ringing in ears	☐ Less diplomatic than normal
☐ Mood swings	☐ Reduced attention span
☐ Blackouts	☐ Indifference to other people
☐ More shallow relationships	☐ Difficulty with problem solving
☐ Less mental stamina	☐ Performance inconsistencies
☐ Verbal learning problems	☐ Slower reaction times

CHECK if you have had any single or multiple symptom(s) listed below. Leave the row blank if the symptom listed does not apply to you.

Symptom List	Felt right after injury	Felt 24-48 hours later	Have symptoms now	Had similar symptom 1-3 months before this injury
Headache				
Dizziness				
Tinnitis (ringing in the ears)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Anxiety				
Pain/difficulty swallowing				
Jaw pain				
Neck pain/soreness				
Neck stiffness				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/mid back pain				
Chest wall pain (rib)				
Low back pain/soreness				
Hip pain				
Leg pain				
Leg numbness/tingling				
Pain shoots down legs				
Knee pain				
Ankle/foot pain				
Other				

AUTOMOBILE ACCIDENT DESCRIPTION

Describe how the crash happened:

_____

_____

_____

_____

_____

Check all that apply to you:

☐ Single-car crash	☐ Two-vehicle crash	☐ More than three vehicles
☐ Rear-end crash	☐ Side crash	☐ Roll over
☐ Head-on crash	☐ Hit guardrail/tree	☐ Ran off road

You were the:

☐ Driver	☐ Front passenger	☐ Rear passenger

Describe the vehicle you were in:

Model, year and make: _____

☐ Subcompact car	☐ Compact car	☐ Mid-sized car
☐ Full-sized car	☐ Pickup truck	☐ Larger than 1 ton vehicle

Check if any of the following vehicle parts broke, bent, or were damaged in your car:

☐ Windshield	☐ Seat frame	☐ Knee bolster
☐ Steering wheel	☐ Side/rear window	☐ _____
☐ Dash	☐ Mirror	☐ _____

<u>Rear-end collisions only</u>: Does your vehicle have?

- ☐ Movable head restraints
- ☐ Fixed, non-movable head restraints
- ☐ No head restraints

Please indicate how your head restraint was positioned at the time of the crash.

- ☐ At the top of the back of your head
- ☐ Midway height of the back of your head
- ☐ Lower height of the back of your head
- ☐ Located at the level of your neck
- ☐ Located at the level of your shoulder blades (upper back) below neck

* Estimate the distance between the back of your head and the front of the head restraint. _____

All Types of Collisions

Yes	No	
☐	☐	Did any of the front or side structures, such as the side door, dashboard, or floorboard of your car, dent inward during the crash?
☐	☐	Was your hand(s) on the steering wheel or dash during the crash?
☐	☐	Did you slide under the seat belt?
☐	☐	Was the door(s) of your vehicle damaged to the point where you could not open the door?

Emergency Care

Yes	No	
☐	☐	Did you go to the emergency department after the accident?
☐	☐	What is the name of the emergency department? _____
☐	☐	When did you go (date and time)? _____
☐	☐	Did you go the emergency department in an ambulance?
☐	☐	Did you or another person drive you to the emergency department?
☐	☐	Were you hospitalized overnight?
		Did the emergency department doctor take x-rays? Check which ones:
		☐ Skull
		☐ Neck
		☐ Low back
		☐ Arm or leg
☐	☐	Did the emergency department doctor give you pain medication?
☐	☐	Did the emergency department doctor give you muscle relaxants?
☐	☐	Did you have any cuts or lacerations?
☐	☐	Did you require any stitching for the cuts?
☐	☐	Were you given a neck collar or back brace to wear?

Have you been unable to work since the injury?

☐ Yes ☐ No If yes, were you off work ☐ partially or ☐ completely?

Please list the dates off work: _____ to _____

Describe the other vehicle (Model, year and make):

☐ Subcompact car	☐ Compact car	☐ Mid-sized car
☐ Full-sized car	☐ Pickup truck	☐ Larger than 1 ton vehicle

Estimated crash speeds:

Estimate how fast your vehicle was moving at the time of the crash. _____ Kmph

Estimate how fast the other vehicle was moving at the time of the crash. _____ Kmph

At the time of impact your vehicle was:

☐ Slowing down ☐ Stopped ☐ Gaining speed ☐ Moving at a steady pace

At the time of the impact the other vehicle was:

☐ Slowing down ☐ Stopped ☐ Gaining speed ☐ Moving at a steady pace

During and after the crash, your vehicle:

☐ Kept going straight, not hitting anything
☐ Kept going straight, hitting the car in front
☐ Was hit by another vehicle
☐ Spun around, not hitting anything
☐ Spun around, hitting another car
☐ Spun around, hitting object other than another car

Describe yourself during the crash (check only the areas that apply to you):

☐ You were unaware of the impending collision.
☐ You were aware of the impending crash and relaxed before the collision.
☐ You were aware of the impending crash and braced yourself.
☐ Your body, torso, and head were facing straight ahead.
☐ You had your head/or torso turned at the time of collision:
_____ Turned to left _____ Turned to right
☐ You were intoxicated (alcohol) at the time of the crash.
☐ You were wearing a seat belt.
If yes, does your seat belt have a shoulder harness? ☐ Yes ☐ No
☐ You were holding onto the steering wheel at the time of impact.

Indicate if your body hit something or was hit by any of the following:
Draw lines and match the left side to the right side.

Head	Windshield
Face	Steering wheel
Shoulder	Side door
Neck	Dashboard
Chest	Car frame
Hip	Another occupant
Knee	Seat
Foot	Seat belt

PATIENT INSTRUCTIONS: It is important for this section to be filled out in detail.

How did you injury your head?

(Check what your head hit or what hit your head)

☐ Windshield ☐ Steering Wheel

☐ Dashboard ☐ Side car window

☐ Other passenger ☐ Mirror

☐ Other _____

What part of your head was hit?

☐ Front ☐ Back ☐ Left Side

☐ Right side ☐ Top

☐ Other _____

History

Yes	No	
☐	☐	Did you lose consciousness or black out for any time (seconds or minutes) after the head injury? How long? _____
☐	☐	Have you lost any memory before the head injury?
☐	☐	Have you lost any memory or has your memory been different since the head injury?
☐	☐	Did you have a lump or bruise after the head injury? Where?_____
☐	☐	Have you had any head injuries in your past (include childhood)?
☐	☐	Have you seen other doctors for this head injury?
☐	☐	Have you had any x-rays taken?
☐	☐	Have you had a computed tomography (CT) or magnetic resonance imaging (MRI) scan taken of your head?

When did you first notice any pain after injury?

☐ Immediately ☐ Hours after injury ☐ Days after injury

If you did not see a doctor for the first time within the first week, indicate why.

Check all that apply.

☐ No pain was noticed

☐ No transportation

☐ I thought pain would go away

☐ I had no insurance money

☐ No appointment schedule available

☐ Work/home schedule conflicts

☐ I took hot showers/used ice/heat

☐ I self-treated with over the counter drugs

Patient Check List For Whiplash-Associated Disorders

SYMPTOM CHECKLIST

For each symptom, check Yes (if present) or No (if not present), and rate the severity on a scale of 0 – 10 where 0 is "No Pain" and 10 is "Worst Pain Possible".

1. Neck or should pain

No Pain — Worst Pain Possible

0	1	2	3	4	5	6	7	8	9	10

2. Upper or Mid-back Pain

No Pain — Worst Pain Possible

0	1	2	3	4	5	6	7	8	9	10

3. Low back pain

No Pain — Worst Pain Possible

0	1	2	3	4	5	6	7	8	9	10

4. Headache

No Pain — Worst Pain Possible

0	1	2	3	4	5	6	7	8	9	10

5. Arm Pain

No Pain — Worst Pain Possible

0	1	2	3	4	5	6	7	8	9	10

6. Hand Pain

No Pain — Worst Pain Possible

0	1	2	3	4	5	6	7	8	9	10

7. Face or Jaw Pain

No Pain — Worst Pain Possible

0	1	2	3	4	5	6	7	8	9	10

8. Leg Pain

No Pain — Worst Pain Possible

0	1	2	3	4	5	6	7	8	9	10

9. Foot Pain

No Pain — Worst Pain Possible

0	1	2	3	4	5	6	7	8	9	10

10. Abdominal or Chest Pain

No Pain — Worst Pain Possible

0	1	2	3	4	5	6	7	8	9	10

11. Feeling of numbness tingling in arms or hands? ☐ Yes ☐ No

Patient Check List For Whiplash-Associated Disorders

12. Feeling of numbness, tingling in legs or feet? ☐ Yes ☐ No

13. Dizziness or unsteadiness? ☐ Yes ☐ No

14. Vision problems? ☐ Yes ☐ No

15. Hearing problems? ☐ Yes ☐ No

16. Anxiety or worry? ☐ Yes ☐ No

17. Nausea or vomiting? ☐ Yes ☐ No

18. Difficulty swallowing? ☐ Yes ☐ No

19. Problems concentrating or with memory? ☐ Yes ☐ No

20. Loss of consciousness? ☐ Yes ☐ No

21. Have the injuries prevented you from carrying out any of the following?

- ☐ Daily home activities
- ☐ Employment
- ☐ Schooling
- ☐ Sports or recreation
- ☐ Other _____

22. Do you think your injury will?

- ☐ Get better soon
- ☐ Get better slowly
- ☐ Never get better
- ☐ Don't know

NECK, SHOULDER, UPPER BACK PAIN AND DISABILITY INDEX (VERNON-MIOR)

Patient Name: _____ File #: _____ Date: _____

PLEASE READ INSTRUCTIONS:
This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please mark in each section only ONE box, which most closely, describes your problem. You may write in the margins also to describe you situation more clearly.

SECTION 1 – PAIN INTENSITY
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 – PERSONAL CARE
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself, and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING
- ☐ I can lift heavy weights without causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor; but can manage if items are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – WORK
- ☐ I can do as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I can't do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 5 – HEADACHES
- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 – CONCENTRATION
- ☐ I can concentrate fully with no difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

SECTION 7 – SLEEPING
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 2-3 hours.
- ☐ My sleep is greatly disturbed for up to 3-5 hours.
- ☐ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING
- ☐ I can drive my car without neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate pain.
- ☐ I can't drive as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I can't drive my car at all because of neck pain.

SECTION 9 – READING
- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I can't read at all.

SECTION 10 – RECREATION
- ☐ I have no neck pain during all recreational activities.
- ☐ I have some neck pain with all recreational activities.
- ☐ I have some neck pain with a few recreational activities.
- ☐ I have neck pain with most recreational activities.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I can't do any recreational activities due to neck pain.

Total Score: ____/50

Rate the severity of your pain by checking one box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

The Roland-Morris Low Back Pain and Disability Questionnaire

Patient name: _____ Date: _____

Please read instructions: When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try to get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I only stand up for short periods of time because of my back.
- ☐ Because of my back, I try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair because of my back.
- ☐ My back is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back.
- ☐ I have trouble putting on my sock (or stockings) because of the pain in my back.
- ☐ I can only walk short distances because of my back pain.
- ☐ I sleep less well because of my back.
- ☐ Because of my back pain, I get dressed with the help of someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.