CLEARBROOK
CHIROPRACTIC AND MASSAGE

In order for you to access ICBC coverage for treatment we need you to consent to our office sending reports to ICBC and communicating with ICBC regarding your claim. Please read and sign the consent, honesty, and compliance statement below.

I consent for Clearbrook Chiropractic and Massage to exchange information with ICBC relevant to my motor vehicle accident claim. This information may include information regarding my history, examination, diagnosis, and plan of management. This exchange may be via ICBC's Online Health Care Invoicing and Reporting Application (HCPIR), facsimile, e-mail, or verbal communication on the phone.

I acknowledge that I have provided Clearbrook Chiropractic and Massage with information that is truthful and honest regarding my history and ICBC claim.

I also commit myself to a trial of therapy with Clearbrook Chiropractic and Massage and to comply with the treatment plan recommended to me by my chiropractor or massage therapist. Non-compliance with treatment in the form of frequently missed appointments, no-shows, or long absences from treatment will result in discharge from the ICBC program and may affect your case with ICBC.

Signed at Clearbrook Chiropractic and Massage, on _____
Date

_____ _____
Participant's Printed Name Witness Printed Name

_____ _____
Participant's Signature Witness Signature

Personal information is being collected under Section 26 of the Freedom of Information and Protection of Privacy Act (BC) and Section 28 or 28.1 of the Insurance (Vehicle) Act (BC) for the purpose of obtaining a health care report in order to investigate, manage or settle a claim.

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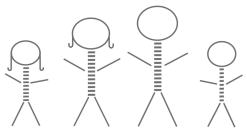


CLEARBROOK
CHIROPRACTIC AND MASSAGE

Motor Vehicle Accident Questionnaire

Full Name: _____ Male ☐ Female ☐

Date of Birth (D/M/Y): _____/_____/_____/ Age: _____

Home Address: _____ City: _____Province: _____

Postal Code: _____ Care-Card number: _____

Telephone: (Home): _____ (Cell): _____

(E-mail): _____

Motor Vehicle Accident Info
ICBC Claim Number: _____
Date of Accident: _____ Time of Accident: _____
Location of Accident (City and Intersection): _____

Were you: Driver ☐ / Passenger ☐ / Pedestrian ☐ / Cyclist ☐ / Vehicle was Parked ☐
If passenger, were you sitting in the front seat or back? Sitting on left side of the vehicle or the right side?
_____
Were you struck from: Behind ☐ / Front ☐ / Driver's Side (Left) ☐ / Right ☐

Describe **how** the accident happened?

Check the box that applies:
I went to the hospital after the accident: Yes ☐ / No ☐
Name of hospital: _____
I saw a medical doctor after the accident: Yes ☐ / No ☐
List the names of MDs: _____
I saw a chiropractor or therapist after the accident: Yes ☐ / No ☐
List the names of chiropractors or therapists: _____
After the accident I had a X-ray ☐ / CT ☐ / MRI ☐ / No Imaging ☐
Did they find anything? _____
I sustained a fracture as a result of the accident: Yes ☐ / No ☐
I saw the accident coming or had prior warning before the accident: Yes ☐ / No ☐
My head or body was rotated at the time of the accident: Yes ☐ / No ☐
I was wearing a **seatbelt**: Yes ☐ / No ☐ The **airbags** deployed: Yes ☐ / No ☐
My head restraint was positioned too low or far from your head at the time of the accident: Yes ☐ / No ☐
I was hit by a vehicle much larger than my own (i.e large truck): Yes ☐ / No ☐
My vehicle flipped, or was pushed into traffic, or involved high speed (>100km/hr): Yes ☐ / No ☐
Police, fire truck or ambulance attended the scene of the accident: Yes ☐ / No ☐
There was a death as a result of the accident: Yes ☐ / No ☐

List any conditions you had **prior to the accident**:
Neck pain ☐ / Mid-back pain ☐ / Low-back pain ☐ / Headaches ☐ / Arm pain ☐ / Leg pain ☐

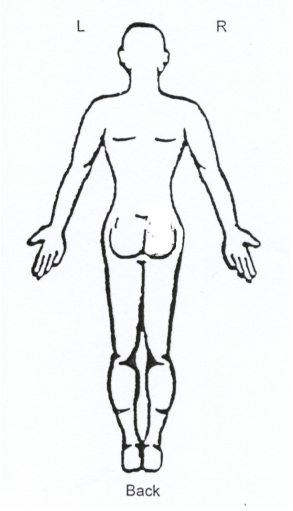
List any **ongoing** conditions you have:

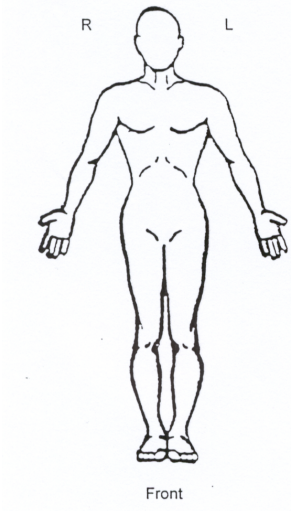
Diabetes ☐	Heart Disease / Stroke ☐	Osteoporosis ☐
Arthritis ☐	Spinal Fusions ☐	Double Jointed / Ligament laxity ☐
Cancer ☐	Sciatica/Disc Herniation ☐	Current or Recent Pregnancy ☐
Anemia/Blood Disorder ☐	Psychological Disorder ☐	Other: _____

Check all injuries that are a **direct result** of your motor vehicle accident:

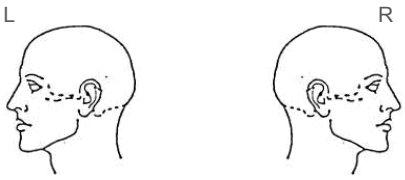
Neck pain ☐ / Mid-back pain ☐ / Low-back pain ☐ / Headaches ☐ / Arm pain ☐ / Leg pain ☐ / Other: _____

Mark the diagram below to represent **where you feel your symptoms now**:

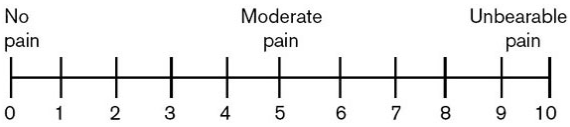




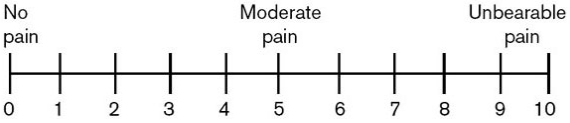
Please use the following symbols:	
Numb	===
Pin/Needle	ooo
Stabbing/sharp	~~~
Stiff/tight	222
Dull/ache	ΔΔΔ
Burning	XXX



Rate your symptoms immediately **after the accident**:



Rate your symptoms **now:**



My complaint is progressively: Getting better ☐ / Staying the same ☐ / Getting worse ☐
This complaint is: Constant ☐ / Comes and goes ☐
Symptoms are worse in: Morning ☐ / Daytime ☐ / Evening ☐
Since the accident what **new** medications have you been taking? _____

Check any additional symptoms you've had since the accident:

Pain with Breathing ☐	Trouble Swallowing ☐	Anxiety/ Stress ☐
Memory Loss ☐	Trouble Breathing ☐	Depression ☐
Dizziness ☐	Trouble Speaking ☐	Fainting/Blackouts ☐
Headache ☐	Loss of Balance ☐	Concussion ☐
Tingling in arms ☐	Clumsiness ☐	Sleep loss ☐
Tingling in legs ☐	Nausea ☐	Night pain ☐
Ringing in the Ears ☐	Fatigue ☐	Loss of bowel/bladder control ☐
Vision Changes ☐	Confusion ☐	Other: _____

Occupation: _____ Employer: _____ Full time or part time? _____
Were you at work prior to the accident? Yes ☐ / No ☐
Since the accident have you been able to work? Yes ☐ / No ☐ List all missed workdays: _____

Which of the following makes your symptoms worse:

Lifting ☐ / Bending forward ☐ / Bending backward ☐ / Twisting ☐
Sneezing ☐ / Straining ☐ / Coughing ☐ / Exercising ☐ / Walking ☐
Sleeping ☐ / Working ☐ / Driving ☐ / Reading ☐ / Concentrating ☐
Dressing ☐ / Homecare ☐ / Playing sports ☐ / Social Activities ☐ Other: _____

Which of the following make your symptoms better:

Ice ☐ / Heat ☐ / Stretching ☐ / Showering or bathing ☐ / Exercising ☐ / Rest ☐
Taking medications ☐ / Bending a particular way ☐ Other: _____

Have you ever had a previous motor vehicle accident? When? _____
Have you ever been hospitalized? Yes ☐ / No ☐ When? _____ Why? _____

Important: These questions ONLY apply to NECK pain.
For example, reading and its effects on neck pain. Lifting and is effect on neck pain only.

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

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 (Washing, Dressing, etc.)

☐ 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 extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

Section 6 – Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7—Work

☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

Section 8 – Driving

☐ I drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments_____
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Important: These questions ONLY apply to your BACK pain or LEG pain
For example, lifting and its effects on back pain.

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem.**

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 (eg. washing, dressing)

- ☐ 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 can manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Walking*

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 2 kilometres
- ☐ Pain prevents me from walking more than 1 kilometre
- ☐ Pain prevents me from walking more than 500 metres
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5: Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6: Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7: Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9: Social Life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10: Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

Oswestry Score: _____

Source: Fairbank JCT & Pynsent, PB (2000) The Oswestry Disability Index. Spine 25(22):2940-2953.Davidson M & Keating J (2001) A comparison of five low back disability questionnaires: reliability and responsiveness. Physical Therapy 2002;82:824.

*Note: Distances of 1mile, ½ mile and 100 yards have been replaced by metric distances in the Walking section.
0-20% (mild), 21-40% (moderate), 41-60% (severe), 61-80% (crippled), 81-100% (bed bound or exaggerating)