



MOTOR VEHICLE COLLISION CASE RECORD

Please take a moment to fill out this Case Record prior to your visit. All information is kept completely CONFIDENTIAL and will go directly to your chart for the practitioner to view.

Name _____ Today's Date _____
(DD / MM / YYYY)

Date of Birth: _____ Alberta Health Number: _____
(DD / MM / YYYY)

=====

Date of injury _____ Time of injury _____
(DD / MM / YYYY)

Is this collision work-related or part of a WCB claim? ☐ NO ☐ YES

WHERE did the collision take place? _____

Please provide a BRIEF statement as to HOW the collision occurred _____

Were there ANY CHARGES arising from the collision? ☐ NO ☐ YES

If yes, WHO WAS CHARGED with causing the collision? _____

TYPES of VEHICLE(s) INVOLVED in the collision: _____

The collision was ☐ Single vehicle ☐ Multi vehicle ☐ Chain reaction ☐ Car/pedestrian

What was the POINT OF IMPACT on your vehicle (identify as many as apply)?

☐ Head-on ☐ Rear-ended ☐ Rt. front ☐ Lt. front ☐ Rt. side
☐ Lt. side ☐ Rt. rear ☐ Lt. rear ☐ Totalled, vehicle written off

POSITION of the patient in the vehicle

☐ Driver ☐ Passenger in Front Seat: Middle ____ Co-driver ____ ☐ Passenger in Rear Seat: Rt ____ Ct ____ Lt ____

A SEATBELT☐ Was not wornWas worn: ☐ Without Shoulder Restraint ☐ With Shoulder Restraint**The HEADREST was high enough to restrain the backward motion of your head?** ☐ YES ☐ NO**The total number of OCCUPANTS in your vehicle was** _____**OTHER THAN YOURSELF, others** ☐ Were not injured☐ Suffered minor injuries (note) _____☐ Suffered moderate injuries (note) _____☐ Suffered severe injuries (note) _____**As a RESULT OF THE IMPACT (identify as many as apply)**☐ You tensed your body for impact ☐ Your neck whipped forward & back ☐ Your body wrenched sideways☐ You were thrown from your seat ☐ Your vehicle propelled into another vehicle ☐ Your vehicle spun☐ You were thrown from vehicle ☐ Your vehicle was crushed (patient was trapped) ☐ Your vehicle rolled**Your estimate the SPEED of the vehicle**☐ That struck you, was _____ km/hr ☐ When you struck, was _____ km/hr**At the time of the collision, your vehicle was** ☐ Parked ☐ Stationary (foot on brake)☐ Slowly rolling ☐ Making a corner ☐ Driving highway speeds ☐ Driving city speeds**Upon impact, you**☐ Did not strike anything ☐ Struck the windshield ☐ Struck the steering wheel☐ Struck the dash ☐ Struck the side glass ☐ Struck the roof☐ Struck the rear window ☐ Were struck by objects loose in vehicle**SYMPTOMS****How did you FEEL immediately following the collision? IDENTIFY all that apply.**☐ Normal☐ Confused _____
(Description of the symptom) (How long the symptom lasted)☐ Dazed _____
(Description of the symptom) (How long the symptom lasted)

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SYMPTOMS (cont'd)

☐ Numbed	_____	_____
	(Description of the symptom)	(How long the symptom lasted)
☐ Shocked	_____	_____
	(Description of the symptom)	(How long the symptom lasted)
☐ Disassociated	_____	_____
	(Description of the symptom)	(How long the symptom lasted)
☐ Stupor, explain	_____	_____
	(Description of the symptom)	(How long the symptom lasted)
☐ Normal consciousness	_____	_____
	(Description of the symptom)	(How long the symptom lasted)
☐ Unconscious	_____	_____
	(Description of the symptom)	(How long the symptom lasted)
☐ Loss of awareness	_____	_____
	(Description of the symptom)	(How long the symptom lasted)
☐ Disoriented	_____	_____
	(Description of the symptom)	(How long the symptom lasted)
☐ Cold sweat	_____	_____
	(Description of the symptom)	(How long the symptom lasted)
☐ Faint	_____	_____
	(Description of the symptom)	(How long the symptom lasted)
☐ Numbness	_____	_____
	(Description of the symptom)	(How long the symptom lasted)
☐ Tingling	_____	_____
	(Description of the symptom)	(How long the symptom lasted)
☐ Other	_____	_____
	(Description of the symptom)	(How long the symptom lasted)

Loss of MOTOR CONTROL ☐ Was not experienced

☐ Was experienced (indicate areas) _____

You experienced (check all that apply)

☐ Nausea ☐ Vomiting ☐ Visual disturbance ☐ Ringing in the ears

SYMPTOMS (cont'd)

You experienced (check all that apply)

- ☐ Immediate pain, indicate where _____
- ☐ Scrapes, indicate where _____
- ☐ Cuts, indicate where _____
- ☐ Cuts requiring stitches, indicate where _____
- ☐ Broken bones, indicate where _____

CARE OR TREATMENT TO DATE

On the day of the collision (indicate as many as apply)

- ☐ You were taken by ambulance to (name of hospital) _____
- ☐ You were physically examined by (name of doctor) _____
- ☐ The course of the examination was _____
- ☐ X-Rays were taken of _____
- ☐ Admitted to hospital (name of hospital) _____
- ☐ Released after examination _____
- ☐ Other _____

On the day of the collision (other than by ambulance)

- ☐ You were taken to Emergency at (name of hospital) _____
- ☐ You were taken to a Medicentre (name of centre) _____
- ☐ You were taken to your Family Doctor (name of doctor) _____
- ☐ You were taken to this office (Vibe Health & Spine) _____
- ☐ You were taken to another chiropractor (name of chiropractor) _____
- ☐ You were taken to your home _____
- ☐ You phoned for Advice (from whom) _____
- ☐ You resumed activities _____

CARE OR TREATMENT TO DATE (cont'd)**Since the collision**

☐ You have not been examined by anyone ☐ You were examined by the examiner (s) indicated below

Examination A.

☐ Examiner's name _____

☐ Type of practice _____

☐ Diagnosis or Explanation provided _____

☐ Treatment provided _____

☐ Date of appointments _____

☐ Improvement experienced _____

☐ No change experienced _____

☐ Conditions that worsened _____

☐ Complications that developed _____

Examination B.

☐ Examiner's name _____

☐ Type of practice _____

☐ Diagnosis or Explanation provided _____

☐ Treatment provided _____

☐ Date of appointments _____

☐ Improvement experienced _____

☐ No change experienced _____

☐ Conditions that worsened _____

☐ Complications that developed _____

CARE OR TREATMENT TO DATE (cont'd)**Examination C.**☐ Examiner's name _____☐ Type of practice _____☐ Diagnosis or Explanation provided _____☐ Treatment provided _____☐ Date of appointments _____☐ Improvement experienced _____☐ No change experienced _____☐ Conditions that worsened _____☐ Complications that developed _____**Examination D.**☐ Examiner's name _____☐ Type of practice _____☐ Diagnosis or Explanation provided _____☐ Treatment provided _____☐ Date of appointments _____☐ Improvement experienced _____☐ No change experienced _____☐ Conditions that worsened _____☐ Complications that developed _____**Previous condition (s) that may have made you MORE VULNERABLE to this collision**☐ Were not present _____☐ Are as follows (state) _____

CARE OR TREATMENT TO DATE (cont'd)

Since the time of the collision to the present time, my **CHIEF COMPLAINTS** are _____

My USUAL LEVEL of pain is

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

The **INJURIES** arising from this collision, are to date ☐ Improving ☐ Still the same
☐ Worse overall ☐ Better on some days than others ☐ Worse in some areas

Due to the collision, PERSONAL BELONGINGS (i.e. glasses, etc.)

☐ Were not lost
☐ That I lost were (state) _____

Please complete all that are applicable

☐ Name of lawyer & law firm _____
☐ Insurance adjuster & company that contacted me _____
☐ My insurance adjuster & company _____
☐ Time & dates that I have had time loss from work _____
☐ Work/home duties that have been compromised by pain suffered from the collision _____

Extra Notes:**Accuracy of Information**

☐ I certify that the above medical information is correct to my knowledge. - Required

Signature: _____ Date: _____