Nicola Valley Massage Therapy
Accident Report

Name ________________________________ Date _______________________________

ICBC Claim # _________________________ Date of Accident __________________________

ICBC Adjuster_________________________ Adjusters Phone # ________________________

Claim Centre Location _______________________Were you driving? Y / N

If no, where were you sitting? Front passenger ____ Rear Left ____ Rear Right ____

Were seat belts worn? Y / N Was the vehicle in motion ____ stopped ____? Turning ____ L / R?

Please describe Accident____

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Where was the vehicle struck?____

Did you anticipate being hit? Y / N Were you conscious at all times Y / N Did you go to Hospital? Y / N

Did you have X-rays? Y / N Immediately after the accident, which areas of your body hurt? ________

____

Could you move all parts of your body? Y / N If no, describe

____

What discomfort did you have in the first 24 hours after the accident? __________________________

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From the time of the accident, have you experienced any of the following symptoms?

Dizziness ____ Sweating ____ Headaches ____ Difficulty swallowing ____ Difficulty sleeping ____

Mood changes ____ Chest disturbances ____ Numbness or tingling ____ (where __________________)

Weakness or trouble moving ____ (where _________________) Rate your discomfort 1-10 __________

Anything else you would like to add? ____

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I understand that ICBC will pay the therapist directly for a portion of the treatment and that I am responsible for the user fee which ICBC may reimburse to me. If for any reason ICBC refuses payment of any visits, I understand that I will be responsible for the entire treatment charge per visit. I verify that all the information contained in the accident information sheet is accurate and understand that any information provided by myself is confidential. There will be no release of patient information to ICBC without my prior authorization.

Patient signature ________________________________ Print Name __________________________________