Kinetic Health

Evidence Based Chiropractic, Registered Massage Therapy, Motion Specific Release, ART, Graston, & Acupuncture.

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Motor Vehicle Accident Report – Information and History

*This report, along with the **Standard Patient Admittance Form**, must **BOTH** be completed **before** arrival at the clinic. This level of detailed information is required in order for us to complete our diagnosis, especially if the case involves future litigation.*

Date: _____

Name: _____
(Family Name) *(First Name)* *(Initials)*

Contact Information

Home Address: _____

Postal Code: _____

Phone (h): _____ Phone (w): _____

Phone (c): _____ Email: _____

Note: All Email addresses are strictly confidential and are never given out to other sources. We maintain a no-spam policy. We use emails to confirm appointments, provide you with exercises, health updates, and clinic newsletters. Email also provides you with a means of asking your practitioner questions when they are not able to answer phone calls (while treating patients). At any time you can chose to opt-out of our email information.

Details

Sex: ☐ Male ☐ Female Occupation: _____

Date of Birth: _____ Age: _____

Marital Status: _____ Name of Spouse: _____

Insurance Company

Policy Number: _____ **Claim Number:** _____

Adjuster Name: _____ **Adjuster Fax #:** _____

Health Information

Alberta Health Care #: _____

Family Doctor: _____

Phone: _____

Emergency Contacts

Who should we contact if there is an emergency?

Name: _____ Phone: _____

Would you like to see a particular Physician?

☐ It does not matter ☐ YES ➔ If YES: ➔ ☐ **Dr. Abelson** ☐ **Dr. Mylonas**

How did you hear about Kinetic Health?

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Describe the Accident

In this Report:

☐ Did you go to the hospital after the accident? ☐ YES ☐ NO

☐ Were X-rays or other diagnostic procedures used at the hospital? ☐ YES ☐ NO
If YES, what treatment procedures were used, and what were the results?

☐ Did you receive treatment or medication at the hospital? ☐ YES ☐ NO
If YES, what treatment or medication or advice was given at the hospital?

☐ Have you seen any other practitioners about this accident (beside the hospital) before coming to our clinic? ☐ YES ☐ NO
If YES, what examinations, treatment, diagnosis or advice have you been given?

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Vehicle Information

Patient Vehicle – check the correct options

What was the **make** of your car/truck?

What was the **size** of your car/truck?

How **far** did your car move after being struck?
_____ in/ft.

What was the approximate **speed** of your car at the time of the collision?
- ☐ Standing still
- ☐ 5 to 10 mph
- ☐ 10 to 15 mph
- ☐ Other _____

If your vehicle was **standing still** at the time of the collision, did you have your foot or feet:
- ☐ Pressed on the brake?
- ☐ Resting on the brake?
- ☐ Off the brake?

What **direction** did the striking vehicle come from?
- ☐ Head-on
- ☐ From behind
- ☐ Right side
- ☐ Left side

Did your vehicle **strike another vehicle** after the initial impact? ☐ YES ☐ NO

Did **air bags** deploy? ☐ YES ☐ NO

What kind of **surface** were you driving on?
- ☐ Dry pavement
- ☐ Wet pavement
- ☐ Gravel
- ☐ Snow
- ☐ Other _____

What direction was your car's **front tire** facing when your vehicle was struck?
- ☐ Straight ahead
- ☐ Right
- ☐ Left

☐ Were you the **driver**? ☐ YES ☐ NO

If **NO**, where were you sitting?
- ☐ Front left
- ☐ Front middle
- ☐ Front right
- ☐ Back left
- ☐ Back middle
- ☐ Back right

Were you **wearing seat belts**? ☐ YES ☐ NO
If *YES*, what kind?
- ☐ Shoulder only
- ☐ Lap only
- ☐ Combination of shoulder and lap

Was there any **damage** to your vehicle? ☐ YES ☐ NO

If *YES,* provide details.

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Striking Vehicle – check the correct options

What was the **make** of the striking car/truck?

What was the approximate **speed** of the striking vehicle at the time of the collision?

☐ Standing still ☐ 5 to 10 mph _____
☐ 10 to 15 ☐ Other _____

What was the **size** of the striking car/truck?

Was there any **damage** to the striking vehicle? ☐ YES ☐ NO

If *YES*, what type and degree of damage?

Vehicular and Patient Relationship

Seat and Head Rest – check the correct options

Did your seat have a **headrest**? ☐ YES ☐ NO

If your seat had a headrest, how far away was the headrest in relationship to the **back of your head**?

☐ 0 to 1 inch
☐ 1 to 2 inches
☐ 2 to 3 inches
☐ Estimated distance _____

If your seat had a headrest, where was the top of the headrest in **relationship** to the **top of your head**?

☐ The top of the headrest came **below** the top of my head by _____ inches.
☐ The top of the headrest was **even** with my head.
☐ The top of the headrest was **above** my head by _____inches.

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Facts about the Patient *during* this MVA Accident

Check the appropriate options

Did you **realize** that your car was going to be hit by the other car?
☐ YES ☐ NO

If *YES*, did you brace your arms and legs?
☐ YES ☐ NO

When your car was struck, **what direction** were you looking?
☐ Straight ahead
☐ Looking down
☐ Looking up
☐ To the left
☐ To the right

Did you lose consciousness after impact?
☐ YES ☐ NO
If *YES*, for how long?

Did your **head strike** any objects during the impact (for example: window, steering wheel, etc.)?
☐ YES ☐ NO

If *YES*, provide details:

Did you experience any of the following after the accident?

☐ Blurred Vision
☐ Confusion
☐ Extreme drowsiness
☐ Loss of Short Term Memory
☐ Nausea or Vomiting
☐ Severe headache
☐ Trouble understanding conversations
☐ OTHER – Provide details

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Facts about the Patient *after* the MVA Accident

Check the appropriate options

What do you remember **immediately after** the accident?

Since the accident have you noticed any of the following symptoms**?**

Headaches	☐ YES	☐ NO
Light-headedness	☐ YES	☐ NO
Dizziness or spinning sensation	☐ YES	☐ NO
Poor concentration	☐ YES	☐ NO
Nausea or vomiting	☐ YES	☐ NO
Irritability, feeling frustrated	☐ YES	☐ NO
Easily tired	☐ YES	☐ NO
Problems sleeping	☐ YES	☐ NO
Intolerance of loud noises	☐ YES	☐ NO
Ringing in the ears	☐ YES	☐ NO
Intolerance bright lights	☐ YES	☐ NO
Feeling anxious	☐ YES	☐ NO
Feeling depressed	☐ YES	☐ NO
Crying for no apparent reason	☐ YES	☐ NO
Memory problems	☐ YES	☐ NO
Lack of awareness of surroundings	☐ YES	☐ NO

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Previous History of MVA Accidents

Check the appropriate options

Have you ever been in a previous motor vehicle accident?

☐ **YES** ☐ **NO**

Patient Signature: _____

☐ If *YES,* please provide all information about prior accidents.

☐ If *NO*, proceed to the next section.

Date and location of previous MVA #1:

1. Injuries sustained during prior accident (MVA):

2. Name of practitioners who provided treatments for prior accident (if known)

3. Were all symptoms from this prior accident resolved before your most recent accident?
   ☐ **YES** ☐ **NO**
   ☐ If *NO*, what symptoms of this prior accident persisted?

   ☐ If *NO*, then did these symptoms affect your function (ability to perform tasks) in any way prior to this most recent accident?
   ☐ **YES** ☐ **NO**

Date and location of previous MVA #2:

1. Injuries sustained during prior accident (MVA):

2. Name of practitioners who provided treatments for prior accident (if known)

3. Were all symptoms from this prior accident resolved before your most recent accident?
   ☐ **YES** ☐ **NO**
   ☐ If *NO*, what symptoms of this prior accident persisted?

   ☐ If *NO*, then did these symptoms affect your function (ability to perform tasks) in any way prior to this most recent accident?
   ☐ **YES** ☐ **NO**

Date and location of previous MVA #3:

1. Injuries sustained during prior accident (MVA):

2. Name of practitioners who provided treatments for prior accident (if known)

3. Were all symptoms from this prior accident resolved before your most recent accident?
   ☐ **YES** ☐ **NO**
   ☐ If *NO*, what symptoms of this prior accident persisted?

   ☐ If *NO*, then did these symptoms affect your function (ability to perform tasks) in any way prior to this most recent accident?
   ☐ **YES** ☐ **NO**

   ☐

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Chief Complaints after this Motor Vehicle Accident (MVA)

Provide required details
Describe all the symptoms and conditions from which you suffered **after the current MVA accident**.
Describe the **physical problems** that you have. Use additional pages if necessary.

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Motor Vehicle Accident Report – Information and History

What are your primary injuries resulting from this motor vehicle accident?
Please list each area or area of symptoms of the body separately.

Chief Complaint #1:

Area of injury:

Onset:

Is this area of injury a direct result of this MVA:
☐ **YES** ☐ **NO**

Provocative Factors:

What makes this area of complaint worse?

What makes this area of complaint better?

Quality of Pain:

What words would you use to describe the pain?

Radiation of Pain:

Where is the pain located, and does it radiate to anywhere else from this point?

Severity of Pain:

On a scale from 1 to 10, 1 being minimal pain and 10 being worst pain you can imagine, where on this scale is your current level of pain

1 2 3 4 5 6 7 8 9 10

Time:

☐ The pain is constant.
☐ The pain worse in the morning.
☐ The pain worse in the evening.
☐ The level of pain varies with body position (sitting, standing, lying down).
☐ The level of pain is worse with motion.
☐ The level of pain is better with motion.

Chief Complaint #2:

Area of injury:

Onset:

Is this area of injury a direct result of this MVA:
☐ **YES** ☐ **NO**

Provocative Factors:

What makes this area of complaint worse?

What makes this area of complaint better?

Quality of Pain:

What words would you use to describe the pain?

Radiation of Pain:

Where is the pain located, and does it radiate to anywhere else from this point?

Severity of Pain:

On a scale from 1 to 10, 1 being minimal pain and 10 being worst pain you can imagine, where on this scale is your current level of pain

1 2 3 4 5 6 7 8 9 10

Time:

☐ The pain is constant.
☐ The pain worse in the morning.
☐ The pain worse in the evening.
☐ The level of pain varies with body position (sitting, standing, lying down).
☐ The level of pain is worse with motion.
☐ The level of pain is better with motion.

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Chief Complaint #3:

Area of injury:

Onset:

Is this area of injury a direct result of this MVA:
☐ **YES** ☐ **NO**

Provocative Factors:

What makes this area of complaint worse?

What makes this area of complaint better?

Quality of Pain:

What words would you use to describe the pain?

Radiation of Pain:

Where is the pain located, and does it radiate to anywhere else from this point?

Severity of Pain:

On a scale from 1 to 10, 1 being minimal pain and 10 being worst pain you can imagine, where on this scale is your current level of pain

1 2 3 4 5 6 7 8 9 10

Time:

☐ The pain is constant.
☐ The pain worse in the morning.
☐ The pain worse in the evening.
☐ The level of pain varies with body position (sitting, standing, lying down).
☐ The level of pain is worse with motion.
☐ The level of pain is better with motion.

Chief Complaint #4:

Area of injury:

Onset:

Is this area of injury a direct result of this MVA:
☐ **YES** ☐ **NO**

Provocative Factors:

What makes this area of complaint worse?

What makes this area of complaint better?

Quality of Pain:

What words would you use to describe the pain?

Radiation of Pain:

Where is the pain located, and does it radiate to anywhere else from this point?

Severity of Pain:

On a scale from 1 to 10, 1 being minimal pain and 10 being worst pain you can imagine, where on this scale is your current level of pain

1 2 3 4 5 6 7 8 9 10

Time:

☐ The pain is constant.
☐ The pain worse in the morning.
☐ The pain worse in the evening.
☐ The level of pain varies with body position (sitting, standing, lying down).
☐ The level of pain is worse with motion.
☐ The level of pain is better with motion.

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Chief Complaint #5:

Area of injury:

Onset:

Is this area of injury a direct result of this MVA:
☐ **YES** ☐ **NO**

Provocative Factors:

What makes this area of complaint worse?

What makes this area of complaint better?

Quality of Pain:

What words would you use to describe the pain?

Radiation of Pain:

Where is the pain located, and does it radiate to anywhere else from this point?

Severity of Pain:

On a scale from 1 to 10, 1 being minimal pain and 10 being worst pain you can imagine, where on this scale is your current level of pain

1 2 3 4 5 6 7 8 9 10

Time:

☐ The pain is constant.
☐ The pain worse in the morning.
☐ The pain worse in the evening.
☐ The level of pain varies with body position (sitting, standing, lying down).
☐ The level of pain is worse with motion.
☐ The level of pain is better with motion.

Chief Complaint #6:

Area of injury:

Onset:

Is this area of injury a direct result of this MVA:
☐ **YES** ☐ **NO**

Provocative Factors:

What makes this area of complaint worse?

What makes this area of complaint better?

Quality of Pain:

What words would you use to describe the pain?

Radiation of Pain:

Where is the pain located, and does it radiate to anywhere else from this point?

Severity of Pain:

On a scale from 1 to 10, 1 being minimal pain and 10 being worst pain you can imagine, where on this scale is your current level of pain

1 2 3 4 5 6 7 8 9 10

Time:

☐ The pain is constant.
☐ The pain worse in the morning.
☐ The pain worse in the evening.
☐ The level of pain varies with body position (sitting, standing, lying down).
☐ The level of pain is worse with motion.
☐ The level of pain is better with motion.

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Clinic Information

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
10:00 AM to 7:00 PM	9:00 AM to 7:00 PM	8:00 AM to 6:00 PM	10:00 AM to 7:00 PM	7:00 AM to 5:00 PM	9:00 to Closing	Closed

Note: Kinetic Health is closed on all statutory holidays.

Fee Schedule

- For information about specific fees, please phone our clinic at **403-241-3772.**
- Payment is due upon services being rendered. We kindly accept cash, debit card, MasterCard, Visa and American Express.
- In ALL Cases: Patients are responsible for any payments that are not reimbursed by their insurance. Ultimately, it is the patient's responsibility to pay for all costs incurred at Kinetic Health Clinic.

Extended Health Insurance

(We Submit Claims from Most Health Policies)

Both TELUS Health and BlueCross Health Care now offer a secure system that links us directly to your health care insurance, and allows us to submit your treatment claims directly to your insurance company. We, at Kinetic Health, are happy to submit insurance claims on your behalf - immediately after your payment has been processed by Kinetic Health.

All we need from you is some basic information, along with your authorization, so that we can set up the *Direct Claims Submissions* on your behalf. Here is the simple process:

1. Provide your insurance information to Kinetic Health.
2. Sign to authorize and allow Kinetic Health to submit a claim on your behalf.
3. Immediately after your treatment, pay for your treatment at the front desk.
4. We submit your claims information directly to your insurance company via a secure system.
5. Within one to three weeks (in most cases) your insurance company will either mail you a cheque, or deposit the claim amount directly into your bank account (depending on the arrangements you have made with your insurance company).

The amount of reimbursement you receive is dependent on your insurance coverage. Many insurance plans cover a set amount per year for Chiropractic and Massage treatments, while others cover a percentage of treatment (80% to 100% of treatment costs). It is well worth registering for this process, as the claim is quickly processed, and the money is soon back in your pocket!

Motor Vehicle Accident Cases

Kinetic Health accepts MVA cases. Please be sure to notify the staff at Kinetic Health in advance if your claim is to be processed through MVA insurance.

Worker's Compensations Board

Kinetic Health accepts WCB cases. If your claim is to be processed through WCB insurance, please notify the staff at Kinetic Health in advance.

Contact Information

Phone: 403-241-3772
Fax: 403-241-3846
Email: kinetichealth@shaw.ca
Web Sites: www.kinetichealth.ca / www.releaseyourbody.com

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