ICBC QUESTIONNAIRE

Patient Name:_________________________________ Date of Birth:________________________________
Claim #: _____________________________________ Adjuster: ___________________________________
Adjuster Phone Number: ________________________ Fax Number:________________________________

Accident/ Injury Information:
Date: _______________________________________ Time: _____________________________________
Place: _______________________________________ Police report made? _____ Yes _____ No
Where you at fault in the accident: _____ Yes _____ No
Where were you sitting in the vehicle? __ Driver __ Passenger __Back left __Back middle __Back right
Were you struck from: ___behind ___Right side ___Left side ___Front side ___Driver ___Front seat
___ Passenger ___Back seat
Were you wearing a seatbelt? _____ Yes _____ No If yes, what type: _____ lap belt _____ shoulder belt
Were there headrests? _____ Yes _____ No
Did you see the accident coming? _____ Yes _____ No If yes, were you prepared for impact? ___ yes ___ No
Position of head at impact: ____
Was there loss of consciousness? ____
Were you hospitalized? ___ Yes ___ No If yes, where and for how long: ______________________________
List the extent of injuries as you know them: ____
____

Check all symptoms you have noticed since the accident:

- ☐ Headache
- ☐ Stomach upset
- ☐ Neck pain
- ☐ Neck Stiff
- ☐ Fainting
- ☐ Face flushed
- ☐ Nervousness
- ☐ Irritability
- ☐ Cold sweats
- ☐ Dizziness
- ☐ Light bothers eyes
- ☐ Head seems too heavy
- ☐ Pins and needles in arms
- ☐ Pins and needles in legs
- ☐ Sleeping problems
- ☐ Numbness in fingers
- ☐ Numbness in toes
- ☐ Shortness of breath
- ☐ Depression
- ☐ Chest pain
- ☐ Buzzing in ears
- ☐ Loss of memory
- ☐ Ears ring
- ☐ Loss of balance
- ☐ Constipation
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Fatigue
- ☐ Diarrhea
- ☐ Feet cold
- ☐ Hands cold
- ☐ Back pain
- ☐ Tension
- ☐ Fever
- ☐ Symptoms other than above: ______________________________

Please state the names and specialties of other health care providers from whom you are seeing in regards to injuries sustained in the above described accident: ____
Dates of lost work: ____
Total Disability from: ______________ to ______________
Partial Disability from: ______________ to ______________
Insurance company or person responsible for injuries: ____

Do you have a lawyer that has advised you in this case? _____ Yes _____ No

If yes, Lawyer's Name and Firm: ____