## ICBC Questionnaire

Name:____________________________ Date:______________________________

Claim # __________________________ Adjuster:___________________________

**Accident/ Injury Information:**

Date:________________________ Time:______________________________

Place:_______________________ Police Report: yes_______ no________

Position in Car: driver_______ front passenger______ back seat _________

Headrests: yes____ no_____ Seatbelts: yes____ no____

Type of impact: head on ______ rear ended ____ side impact____

Did you see the accident coming? Yes____ No ____

Were you prepared for Impact? Yes____ No ____

Was there loss of consciousness? Yes____ No ____

Were you hospitalized? Yes____ No ____ If yes, for how long? ____________

Were Xrays taken? Yes____ No ____ If yes, what area? _______________________

List the extent of your injuries. _____________________________________________

______________________________________________________________________

**Please check symptoms you have noticed since the accident:**

| | | | |
|---|---|---|---|
| Head ache ___ | Dizziness ____ | Neck pain ____ | Neck stiffness____ |
| Depression ____ | Fatigue ____ | Irritability ____ | Cold Sweats ____ |
| Light sensitivity ___ | Ears Ringing ____ | Loss of Balance ____ | Tension ____ |
| Back Pain ____ | Leg Pain ____ | Hip Pain ____ | constipation ____ |
| Diarrhea ____ | Loss of smell ____ | Loss of taste ____ | loss of Memory ____ |
| Chest Pain ____ | Shortness of Breath ____ | Fever ____ | |
| Heavy Head ____ | Pins & needles in Arms ____ | Pins & Needles in Legs ____ | |
| Sleep problems____ | Numbness in Arms ____ | Numbness in Legs ____ | |

Other symptoms: _______________________________________________________

Please list the names of other Professionals who are treating you for these injuries:

______________________________________________________________________

Dates of lost work:__________________ Total disability from:________ to: _________

Do you have a Lawyer? Yes____ No____

If yes, Name & phone number:__________________________________________