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Accident Benefits: Please note according to the Financial Services Commission of Ontario (FSCO) the regulatory body for Motor vehicle insurance companies, ALL automobile accidents involving bodily injury must be reported to the police. Claims for certain accident benefits must be made within 7 days. Please contact your adjuster for further information.

AUTHORIZATION FOR ACTING UPON

Date:_____

To Whom It May Concern:

I hereby authorize Taylor Creek Chiropractic to act on my behalf to deal with the appropriate claims caused by the automobile accident on: _____

Patient Name (print): _____ **DOB:** _____

Patient Signature: _____

Name of Auto Insurance Co: _____

Name of Insurance Adjuster:_____

Claim Number: _____

Policy Number: _____

You will need to complete the **Application for Accident Benefits OCF-1** when you are applying **for the first time** as a result of an accident, including if you are applying for income replacement benefits.

Additionally, the **Permission to Disclose Health Information OCF-5** must be completed.

Disability Certificate OCF-3 If your insurance company asks you to, please fill out the first section and return the form to the office. The second half of the document needs to be completed by the Doctor.

The Doctors will complete online the **Treatment Confirmation Form OCF-23** to confirm treatment received under the Minor Injury Guideline (some exceptions apply).

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Motor Vehicle Accident Claimant Information

Name: _____

Today's Date: (DD/MM/YR)_____

Date of Birth: (DD/MM/YR)_____

Date of the collision: (DD/MM/YR)_____

Full Address:_____

_____

Email Address:_____

Home Telephone #: _____ Cell #_____

Your Car Insurance Information

Name and Address of Your Car Insurance Company:

Adjuster's Name:	Telephone #: Fax #: Email:
Name of Policy Holder: ☐ Same as applicant or ☐Other/ Name:	
Claim #:	Policy #:

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Extended Health Care Benefits (EHCB):

Do you have extended health coverage for chiropractic or massage therapy? ☐ YES ☐ NO

The Statutory Accident Benefits Schedule requires that all of your EHCB must first be exhausted PRIOR to us submitting an invoice to your auto insurance company.

We appreciate your cooperation in promptly providing us with a Statement Benefit from your Extended Health Insurance detailing your eligible reimbursement.

Extended Health Care Benefits (1)

Name of your Extended Health Insurance Company	
Name of Policy Holder	
Policy #	
Group #	
Yearly Maximum for Chiropractic Care:	
Yearly Maximum for Registered Massage Therapy	
Fiscal Year Renewal date is:	
Have you submitted any claims to your EHCB since the beginning of your fiscal year	☐Yes / ☐No

Extended Health Care Benefits (2)

Name of your Extended Health Insurance Company	
Name of Policy Holder	
Policy #	
Group #	
Yearly Maximum for Chiropractic Care:	
Yearly Maximum for Registered Massage Therapy	
Fiscal Year Renewal date is:	
Have you submitted any claims to your EHCB since the beginning of your fiscal year	☐Yes / ☐No

I confirm that the above information is accurate and I understand that I must promptly provide my EHCB statement. I also understand that any funds reimbursed to me for Chiropractic care since the date of my car accident must be applied to my account.

Signature:_____ Date: _____

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Motor Vehicle Collision Injury Information

Name:_____Date:_____

Date of Collision:_____

Were you the driver or the passenger of the vehicle? Driver ☐ Passenger ☐ (front or back)
Were you wearing a seat belt? Yes ☐ No ☐
Was the vehicle moving or stopped when it was hit? Moving ☐ Stopped ☐
What were you attempting to do at the time of impact? (E.g. Making a left/right hand turn, changing lanes…)_____
Did you see the vehicle coming towards you as the collision occurred (did you brace yourself for the impact?)_____

How was the vehicle struck? (E.g. Rear-end, Head On, Side)_____

Were the airbags activated? Yes ☐ No ☐_____

Did your head strike the windshield, side window, or did your chest strike the steering wheel? Explain:
_____

Were you wearing glasses or a hat at the time of the collision? Yes ☐ No ☐
If yes, did the impact throw them off? Yes ☐ No ☐
Did you have any cuts / bruises / stitches? (Describe where?) _____

How did you react to the collision? _____
Were you able to get out of the car? Yes ☐ No ☐ Were you unconscious? Yes ☐ No ☐
Were you able to get out of the car on your own? Yes ☐ No ☐
Were you taken to the hospital? Yes ☐ No ☐ If yes, how? Ambulance ☐ Other Means ☐
Did they use a stretcher? Yes ☐ No ☐ Did they use a neck brace? Yes ☐ No ☐
Was your car drivable following the collision? Yes ☐ No ☐
How long did it take following the collision before you felt the pain? _____

Where did you feel the pain? _____

Rate your pain on a scale of 0 to 10. (0=No pain 10=Severe)

0 1 2 3 4 5 6 7 8 9 10

What type of pain is it?

Burning ☐	Aching ☐	Dull ☐	Sharp ☐	Stabbing ☐
Tingling ☐	Numbness ☐	Shooting ☐	Cramps ☐	Stiffness ☐
Swelling ☐	Other ☐ _____			

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Who did you consult after the collision (E.g. Chiropractor, Physiotherapist, Medical Doctor...) before coming into our office?_____

What kind of treatments or medication did you receive from them?_____

What other changes have you noticed since the collision?

- ☐ Difficulty Sleeping (number of hours you are sleeping post collision _____ number of hours you were sleeping before the collision_____)
- ☐ Muscle Tension / Spasms (where?)_____
- ☐ Digestive Problems (explain) _____
- ☐ Headaches (how often?) _____
- ☐ Stiffness (where? is it constant or worse at certain times?) _____
- ☐ Limited Movements (of what body parts?)_____
- ☐ Decreased Appetite
- ☐ Irritable
- ☐ Memory Problems
- ☐ Ringing in the Ears
- ☐ Fatigue
- ☐ Visual Disturbances
- ☐ Low Back Pain

List any other changes that are not mentioned:_____

Has this problem prevented you from doing anything (going to work, hobbies, activities, sleeping, sitting, standing, walking, life in general, etc....)? Describe how these activities of daily living have been affected? Please list ***anything*** that you ***can't*** do now that you ***used to be able to do*** with ease and explain ***why*** you can't do these activities now. (E.g. Too much pain, fatigue, headaches...)

Which activities are difficult to perform?

Sitting ☐ Standing ☐ Walking ☐ Bending ☐
Lying Down ☐ Reaching Up ☐ Picking things up from the floor ☐

Are you currently employed: Y ☐ N ☐ If yes, have you lost any time at work/ or did you have to modify your work due to this accident, please describe:_____

Have you ever broken any bones or torn ligaments in the past? Yes ☐ No ☐
If yes, specify: _____

Have you ever injured the present area of pain in your body in the past? Yes ☐ No ☐
If yes, specify: _____

Have you ever been a recipient of Workers' Compensation Benefits? Yes ☐ No ☐
If yes, specify type of injury: _____

Have you ever had a previous motor vehicle collision? Yes ☐ No ☐
If yes, specify what injuries you sustained: _____

Signature: _____ Date: _____

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Informed Consent to Chiropractic Care

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures, or muscles and ligament strains and sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence do not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of skin irritation/ bruising with the use of some types of instrument or therapy offered by some doctors of chiropractic.

e) Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that association with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my Chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care in this office.

Dated this_____**day of** _____**, 20**_____**.**

Patient Signature (Legal Guardian) Witness of Signature

Print Name Print Name

3735 St Joseph Blvd, Suite A
Orléans, Ontario | K4A 0Z7 | 613.830.3337
admin@taylorcreekchiro.com | TaylorCreekChiro.com

HEADACHE DISABILITY INDEX

NAME: _____ DATE: _____ AGE: ____ SCORES TOTAL: ____; E____; F____
(100) (52) (48)

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: [1] 1 per month [2] more than but less than 4 per month [3] more than one per week.
2. My headache is: [1] mild [2] moderate [3] severe

INSTRUCTIONS: ***PLEASE READ CAREFULLY:*** The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each item as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.	☐	☐	☐
F2. Because of my headaches I feel restricted in performing my routine daily activities.	☐	☐	☐
E3. No one understands the effect my headaches have on my life.	☐	☐	☐
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.	☐	☐	☐
E5. My headaches make me angry.	☐	☐	☐
E6. Sometimes I feel that I am going to lose control because of my headaches	☐	☐	☐
F7. Because of my headaches I am less likely to socialize.	☐	☐	☐
E8. My spouse/significant other, or family and friends have no idea what I am going through because of my headaches.	☐	☐	☐
E9. My headaches are so bad that I feel I am going to go insane.	☐	☐	☐
E10. My outlook on the world is affected by my headaches.	☐	☐	☐
E11. I am afraid to go outside when I feel a headache is starting.	☐	☐	☐
E12. I feel desperate because of my headaches.	☐	☐	☐
F13. I am concerned that I am paying penalties at work or at home because of my headaches.	☐	☐	☐
E14. My headaches place stress on my relationships with family or friends.	☐	☐	☐
F15. I avoid being around people when I have a headache.	☐	☐	☐
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	☐	☐	☐
F17. I am unable to think clearly because of my headaches.	☐	☐	☐
F18. I get tense (e.g. muscle tension) because of my headaches.	☐	☐	☐
F19. I do not enjoy social gatherings because of my headaches.	☐	☐	☐
E20. I feel irritable because of my headaches.	☐	☐	☐
F21. I avoid traveling because of my headaches.	☐	☐	☐
E22. My headaches make me feel confused.	☐	☐	☐
E23. My headaches make me feel frustrated.	☐	☐	☐
F24. I find it difficult to read because of my headaches.	☐	☐	☐
F25. I find it difficult to focus my attention away from my headaches and on other things.	☐	☐	☐

Reference: Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital Headache Disability Inventory (HDI). Neurology 1994; 44:837-842

LOW BACK PAIN DISABILITY QUESTIONNAIRE
(ROLAND-MORRIS)

Name _____ Number _____ Date _____

SCORE: _____

When your back hurts, you may find it difficult to do some of the things you normally do.
Mark only the sentences that describe you today.

- ☐ **I stay at home most of the time because of my back.**
- ☐ **I change position frequently to try and get my back comfortable.**
- ☐ **I walk more slowly than usual because of my back.**
- ☐ **Because of my back, I am not doing any jobs that I usually do around the house.**
- ☐ **Because of my back, I use a handrail to get upstairs.**
- ☐ **Because of my back, I lie down to rest more often.**
- ☐ **Because of my back, I have to hold on to something to get out of an easy chair.**
- ☐ **Because of my back, I try to get other people to do things for me.**
- ☐ **I get dressed more slowly than usual because of my back.**
- ☐ **I stand up only for short periods of time because of my back.**
- ☐ **Because of my back, I try not to bend or kneel down.**
- ☐ **I find it difficult to get out of a chair because of my back.**
- ☐ **My back is painful almost all of the time.**
- ☐ **I find it difficult to turn over in bed because of my back.**
- ☐ **My appetite is not very good because of my back pain.**
- ☐ **I have trouble putting on my socks (or stockings) because of pain in my back.**
- ☐ **I sleep less well because of my back.**
- ☐ **Because of back pain, I get dressed with help from someone else.**
- ☐ **I sit down for most of the day because of my back.**
- ☐ **I avoid heavy jobs around the house because of my back.**
- ☐ **Because of back pain, I am more irritable and bad tempered with people than usual.**
- ☐ **Because of my back pain, I go upstairs more slowly than usual.**
- ☐ **I stay in bed most of the time because of my back.**

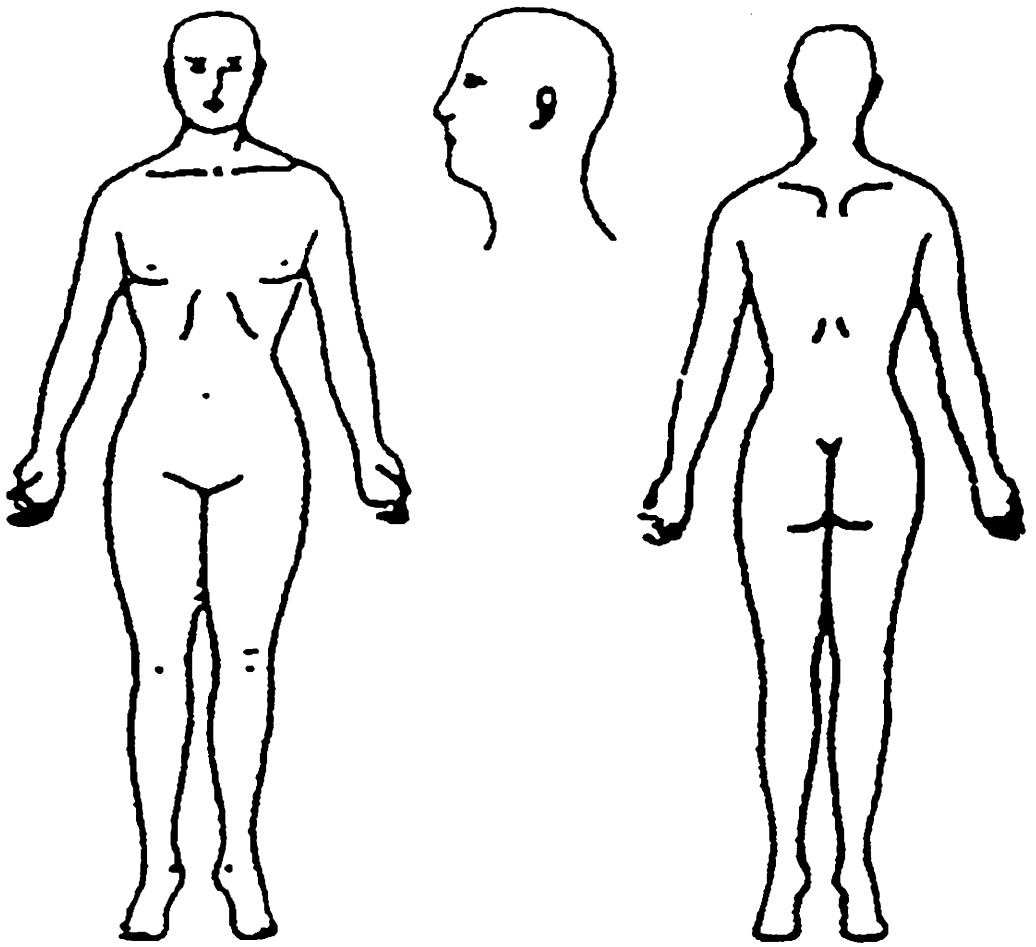
Reference: Roland, Morris. A Study of the Natural History of Back Pain Part 1: Development of a Reliable and Sensitive Measure of Disability in Low-Back Pain. Spine 1983; 8(2): 141-144

SYMPTOM DIAGRAM

Name _____ Number _____ Date _____

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches ΛΛΛΛ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



Reference: Randsford. Spine, Vol. 1, No 2, June 1976

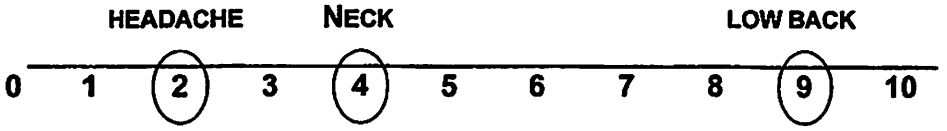
QUADRUPLE VISUAL ANALOGUE SCALE

Name _____ Number _____ Date _____

INSTRUCTIONS: Please circle the number that best describes the question being asked.

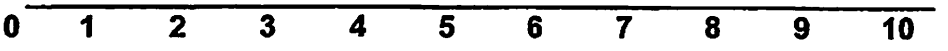
NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

EXAMPLE:

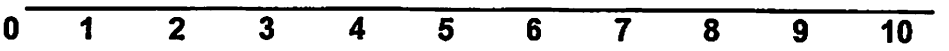


1. What is your pain RIGHT NOW?

2. What is your TYPICAL or AVERAGE pain?



3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?

What percentage of your awake hours is your pain at its worst? _____%

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine* 27, 145-151.

Neck Pain and Disability Index (Vernon-Mior)

Patient Name: _____ **Date:** _____

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes our problem.

SECTION 1 – PAIN INTENSITY
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 – PERSONAL CARE (Washing, Dressing, etc)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3 – LIFTING
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – READING
- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5 – HEADACHES
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 – CONCENTRATION
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentration when I want to.
- ☐ I have a great deal of difficulty in concentration when I want to.
- ☐ I cannot concentrate at all.

SECTION 7 – WORK
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 8 – DRIVING
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9 – SLEEPING
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1hr. sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless)
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 – RECREATION
- ☐ I am able to engage in all recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Pain Severity: Please circle your current level of neck pain

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (extreme pain)

Patient Signature:_____

Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name: _____ **Date:** _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes our problem.

SECTION 1 – PAIN INTENSITY
- ☐ The pain comes and goes and I very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain is comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 – PERSONAL CARE
- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 – LIFTING
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights at the most.

SECTION 4 - WALKING
- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 – SITTING
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favourite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than half hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

SECTION 6 – STANDING
- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain straight away.

SECTION 7 – SLEEPING
- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal night's sleep is reduced by less than ¼
- ☐ Because of pain my normal night's sleep is reduced by less than ½
- ☐ Because of pain my normal night's sleep is reduced by less than ¾
- ☐ Pain prevents me from sleeping in all.

SECTION 8 – SOCIAL LIFE
- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 – TRAVELLING
- ☐ I get no pain whilst travelling.
- ☐ I get some pain whilst travelling but none of my usual forms of travel make it worse.
- ☐ I get extra pain whilst travelling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain whilst travelling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 – CHANGING DEGREE OF PAIN
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Pain Severity: Please circle your current level of low back pain

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (extreme pain)

Patient Signature:_____