EHL HEALTH · DR. ELSE HARRISHOJ LARSEN, D.C., CCOS(C) **DATE:_____**

PATIENT MVA HISTORY

Please Note: The following questionnaire is designed to help us assess your case. It is very important that all questions, when applicable, are answered. Write N/A if not applicable. If further space is required, you may use a blank sheet with question # beside it. Thank you for your cooperation.

RELEASE FORM

I _____ hereby authorize the release of information regarding my physical condition, history, examination, assessment, and management of the injury related to the motor vehicle accident with ICBC, and release Dr. Else H. Larsen DC from any consequence thereof. I understand that the information provided by me may be used to compile records, or to inform my lawyer/ICBC of the details of my accident.

Signed_____ Witness_____ Date _____

PATIENT'S ACCIDENTAL INJURY INFORMATION

Name: _____ Date of Birth: _____ PHN: _____
Date of Accident: _____ Time of Accident: _____am/pm Is your case: ☐ Open ☐ Closed
Claim No: _____ ICBC Adjuster: _____
Adjuster Phone No: _____ E-mail:_____ Fax: _____
Medical Doctor: _____ Phone: _____
Who rendered first treatment: _____ ___ Date and Time: _____
Were you employed before the MVA: _____ Occupation: _____

ACCIDENT INFORMATION

1. Were you: ☐ Driver ☐ Passenger (front) ☐ Passenger (rear) ☐ Pedestrian

2. Were you wearing seatbelts: ☐ Yes ☐ No

3. Type of vehicle: ☐ Auto ☐ Truck ☐ Van ☐ Motorcycle ☐ Motorhome ☐ Bicycle

4. How accident occurred: ☐ Struck by another vehicle ☐ Struck another vehicle ☐ Struck a stationary object ☐ Other: _____

5. Where was your vehicle hit: ☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Right Front ☐ Left Front ☐ Right Rear ☐ Left Rear

6. Where was other vehicle hit: ☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Right Front ☐ Left Front ☐ Right Rear ☐ Left Rear

7. Your approximate speed _____km/h

8. Other vehicle approximate speed _____km/h

9. What occurred at the moment of impact: (Check as many as apply)

☐ Tensed body from impact ☐ Neck whipped forward and back ☐ Neck whipped back and forward
☐ Spine torque and twisted ☐ Thrown over seat ☐ Thrown from vehicle ☐ Pinned in vehicle
☐ Thrown from side to side ☐ Cut and bruised ☐ Other _____

10. Did you strike your: (Check as many as apply)

Head	☐ Lft	☐ Rt	Against the:	☐ Dashboard	☐ Windshield	☐ Steering wheel	☐ Rt Door	☐ Lft Door	☐ Seat Frame	☐ Other
Shoulder	☐ Lft	☐ Rt	Against the:	☐ Dashboard	☐ Windshield	☐ Steering wheel	☐ Rt Door	☐ Lft Door	☐ Seat Frame	☐ Other
Arm	☐ Lft	☐ Rt	Against the:	☐ Dashboard	☐ Windshield	☐ Steering wheel	☐ Rt Door	☐ Lft Door	☐ Seat Frame	☐ Other
Elbow	☐ Lft	☐ Rt	Against the:	☐ Dashboard	☐ Windshield	☐ Steering wheel	☐ Rt Door	☐ Lft Door	☐ Seat Frame	☐ Other
Wrist	☐ Lft	☐ Rt	Against the:	☐ Dashboard	☐ Windshield	☐ Steering wheel	☐ Rt Door	☐ Lft Door	☐ Seat Frame	☐ Other
Hip	☐ Lft	☐ Rt	Against the:	☐ Dashboard	☐ Windshield	☐ Steering wheel	☐ Rt Door	☐ Lft Door	☐ Seat Frame	☐ Other
Knee	☐ Lft	☐ Rt	Against the:	☐ Dashboard	☐ Windshield	☐ Steering wheel	☐ Rt Door	☐ Lft Door	☐ Seat Frame	☐ Other
Ankle	☐ Lft	☐ Rt	Against the:	☐ Dashboard	☐ Windshield	☐ Steering wheel	☐ Rt Door	☐ Lft Door	☐ Seat Frame	☐ Other

11. Were you: (Check as many as apply) ☐ Shaken ☐ Disoriented

12. Were you rendered unconscious: ☐ Yes ☐ No

13. Did you receive medical attention at the scene of the accident: ☐ Yes ☐ No
If yes, please describe: _____

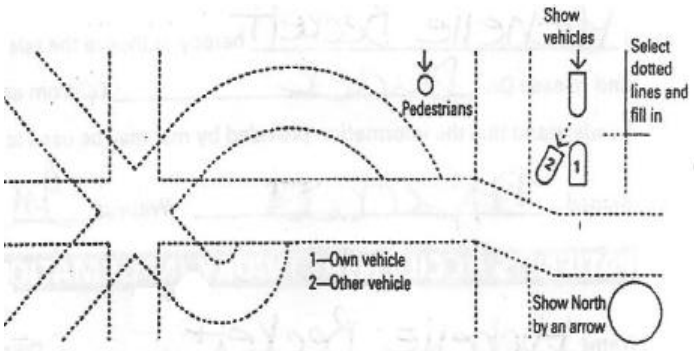
14. Where did you go immediately following the accident:
☐ Hospital ☐ Home ☐ Personal Doctor ☐ To this office ☐ Resumed activities
If hospitalized, please describe: _____

15. Were any x-rays taken following this accident: ☐ Yes ☐ No

If yes, please list: _____

16. In your own words, please describe accident: (Draw accident layout)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____



_____
_____
_____
_____
_____
_____

17. How did you feel immediately after the accident?: _____

_____
_____
_____

18. Were you disabled from the accident: ☐ Yes ☐ No

If yes: partly? _____ For how long: _____ (Ending date)

Totally? _____ For how long: _____ (Ending date)

PRE-ACCIDENT HISTORY

19. Is there a history of pre-existing disorders, accidents or injuries: ☐ Yes ☐ No

If yes, please describe: _____

_____

20. Were you symptom free before the accident: ☐ Yes ☐ No If yes, for how long _____

21. Were any x-rays taken before the accident: ☐ Yes ☐ No If yes, for what part and by whom _____

_____

22. Were you disabled before the accident: ☐ Yes ☐ No

If yes: partly? _____ For how long: _____ (Ending date)

Totally? _____ For how long: _____ (Ending date)

23. Were you off work before: ☐ Yes ☐ No If yes, for how long: _____

Do you anticipate any further time loss: _____

24. For what conditions have you been hospitalized prior to the accident: _____

_____

Name of hospital: _____ Treatment: _____

_____

25. Other treatments, medications and/or examinations (including x-rays, CT scans, MRI, etc) received since this MVA (medica, chiropractic, physiotherapy, orthopedic etc.)

When: _____ By whom?: _____

Did it help?: _____

Treatment/Medication given: _____

_____
_____
_____

PRESENT SYMPTOMS

Please circle as many as apply on each section

26. General Symptoms

☐ Nervousness ☐ Irritability ☐ Fatigue ☐ Depression
☐ Loss of Sleep ☐ Tension ☐ PMS ☐ Jaw Pain

27. Head

☐ Headache ☐ Mild ☐ Moderate ☐ Severe
How often: _____ per ☐ Day ☐ Week ☐ Month
Are they: ☐ Sharp ☐ Dull
Are they: ☐ Constant ☐ Intermittent
Where located: ☐ Forehead ☐ Temples ☐ Behind eyes
☐ Rt side ☐ Lft side ☐ Back of head
☐ Light headed ☐ Blurred vision ☐ Fainting
☐ Memory loss ☐ Double vision ☐ Sensitivity to light
☐ Hearing loss ☐ Loss of balance ☐ Ringing in ears

28. Neck

☐ Pain ☐ Left side ☐ Right side ☐ Both
Pain Level: ☐ Mild ☐ Moderate ☐ Severe
Pain increased: ☐ Forward movement ☐ Backward movement
☐ Rotate head left ☐ Rotate head right
☐ Bend head left ☐ Bend neck right
☐ Stiffness ☐ Muscle spasm ☐ Grinding sounds

29. Shoulders

☐ Pain in joint ☐ Left ☐ Right ☐ Both
☐ Pain across shoulder ☐ Left ☐ Right ☐ Both
☐ Limitation of movement ☐ Left ☐ Right ☐ Both
☐ Tension ☐ Left ☐ Right ☐ Both

30. Arms

☐ Pain in upper arm (right) ☐ Mild ☐ Moderate ☐ Severe
☐ Pain in upper arm (left) ☐ Mild ☐ Moderate ☐ Severe
☐ Pain in elbow (right) ☐ Mild ☐ Moderate ☐ Severe
☐ Pain in elbow (left) ☐ Mild ☐ Moderate ☐ Severe
☐ Pain in forearm (right) ☐ Mild ☐ Moderate ☐ Severe
☐ Pain in forearm (left) ☐ Mild ☐ Moderate ☐ Severe
☐ Pins/needles (arm right) ☐ Mild ☐ Moderate ☐ Severe
☐ Pins/needles (arm left) ☐ Mild ☐ Moderate ☐ Severe
☐ Pins/needles (forearm r) ☐ Mild ☐ Moderate ☐ Severe
☐ Pins/needles (forearm l) ☐ Mild ☐ Moderate ☐ Severe
☐ Numbness in arm (right) ☐ Mild ☐ Moderate ☐ Severe
☐ Numbness in arm (left) ☐ Mild ☐ Moderate ☐ Severe
☐ Numbness in forearm (r) ☐ Mild ☐ Moderate ☐ Severe
☐ Numbness in forearm (l) ☐ Mild ☐ Moderate ☐ Severe

31. Hands

☐ Pain in wrists ☐ Left ☐ Right ☐ Both
Pain level: ☐ Mild ☐ Moderate ☐ Severe
☐ Pain in hands ☐ Left ☐ Right ☐ Both
Pain level: ☐ Mild ☐ Moderate ☐ Severe
☐ Pins and needles (hand) ☐ Left ☐ Right ☐ Both
☐ Numbness (hand) ☐ Left ☐ Right ☐ Both

32. Chest

☐ Deep chest pain ☐ Left ☐ Right ☐ Both
Pain level: ☐ Mild ☐ Moderate ☐ Severe
☐ Pain around ribs ☐ Left ☐ Right ☐ Both
☐ Shortness of breath ☐ Irregular breath

33. Abdominal Symptoms

Pain level: ☐ Mild ☐ Moderate ☐ Severe
☐ Nervous stomach ☐ Constipation ☐ Nausea ☐ Gas
☐ Loss of appetite ☐ Diarrhea ☐ Indigestion ☐ Heartburn

34. Lowback

☐ Upper lumbar pain ☐ Left ☐ Right ☐ Both
Pain level: ☐ Mild ☐ Moderate ☐ Severe
☐ Lower lumbar pain ☐ Left ☐ Right ☐ Both
Pain level: ☐ Mild ☐ Moderate ☐ Severe
☐ Sacro-iliac pain ☐ Left ☐ Right ☐ Both
Pain level: ☐ Mild ☐ Moderate ☐ Severe
☐ Muscle spasm ☐ Left ☐ Right ☐ Both

35. Hips and Legs

☐ Pain in buttocks ☐ Left ☐ Right ☐ Both
Pain level: ☐ Mild ☐ Moderate ☐ Severe
☐ Pain in hip joint ☐ Left ☐ Right ☐ Both
Pain level: ☐ Mild ☐ Moderate ☐ Severe
☐ Pain down leg ☐ Left ☐ Right ☐ Both
Location ☐ Front ☐ Back ☐ Side
Pain radiates to ☐ Knee ☐ Calf ☐ Foot
☐ Numbness down leg ☐ Left ☐ Right ☐ Both
Location ☐ Front ☐ Back ☐ Side
☐ Pins & needles (leg) ☐ Left ☐ Right ☐ Both
Location ☐ Front ☐ Back ☐ Side
☐ Knee pain ☐ Left ☐ Right ☐ Both

36. Feet

☐ Ankle pain ☐ Left ☐ Right ☐ Both
Pain level: ☐ Mild ☐ Moderate ☐ Severe
☐ Swollen Ankle ☐ Left ☐ Right ☐ Both
☐ Foot pain ☐ Left ☐ Right ☐ Both
Pain level: ☐ Mild ☐ Moderate ☐ Severe
☐ Numbness of feet ☐ Left ☐ Right ☐ Both
☐ Swollen feet ☐ Left ☐ Right ☐ Both
☐ Cramps ☐ Left ☐ Right ☐ Both

37. Midback

☐ Pain ☐ Left ☐ Right ☐ Both
Pain level: ☐ Mild ☐ Moderate ☐ Severe
Pain type: ☐ Sharp/Shooting ☐ Dull ache
☐ Muscle Spasms ☐ Left ☐ Right ☐ Both

DISABILITY INFORMATION

		Before Disability		After Disability	
38.	Did (do) you have any discomfort, pain, or restrictions while working or lifting?	☐ Yes	☐ No	☐ Yes	☐ No
39.	Were (are) you able to do almost any physical work activity?	☐ Yes	☐ No	☐ Yes	☐ No
40.	Were (are) you able to do almost any mental work activity?	☐ Yes	☐ No	☐ Yes	☐ No
41.	Were (are) you limited in your lifting in some body positions?	☐ Yes	☐ No	☐ Yes	☐ No

42. Relate you **before** disability capacity for performing such activities as:

Walking	☐ Normal	☐ Limited	☐ Difficult	☐ Painful
Standing	☐ Normal	☐ Limited	☐ Difficult	☐ Painful
Bending	☐ Normal	☐ Limited	☐ Difficult	☐ Painful
Sitting	☐ Normal	☐ Limited	☐ Difficult	☐ Painful

43. Relate you **after** disability capacity for performing such activities as:

Walking	☐ Normal	☐ Limited	☐ Difficult	☐ Painful
Standing	☐ Normal	☐ Limited	☐ Difficult	☐ Painful
Bending	☐ Normal	☐ Limited	☐ Difficult	☐ Painful
Sitting	☐ Normal	☐ Limited	☐ Difficult	☐ Painful

44. After the accident or injury, what symptoms did you notice? _____
_____

45. Are these symptoms constant? ☐ Yes ☐ No

46. Do you notice any numbness, tingling, or loss of strength, etc? ☐ Yes ☐ No

47. Does physical activity increase the symptoms? ☐ Yes ☐ No

48. Is there a particular part of the day when the condition appears to worsen: ☐ Yes ☐ No
Explain: _____

49. Are these symptoms interfering with your: ☐ Work ☐ Daily routine ☐ Sleep
☐ Other: _____
_____

50. Are you at present able to do work or lifting without discomfort, pain, or restrictions: ☐ Yes ☐ No
How much weight are you able to lift: _____lbs

51. What physical work activities can you now perform: _____
_____

52. What mental work activities can you now perform: _____
_____

53. Relate yourself as to the kind of labor you feel you can perform:
☐ Hard ☐ Moderate ☐ Light ☐ Sitting ☐ Full-Time ☐ Part-Time ☐ Not able to work at all

54. Are there any personal activities that you were able to perform before your disability now restricted: ☐ Yes ☐ No
Explain: _____
_____
_____

55. Is your sex function normal: ☐ Yes ☐ No

56. Do you feel your present condition is: ☐ Temporary ☐ Permanent ☐ Don't know
_____

57. Please list any comment you may have: _____
_____
_____
_____
_____
_____

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (ROLAND-MORRIS)

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 only stand up 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 the pain in my back.
- ☐ I only walk short distances because of my back pain.
- ☐ I sleep less well because of my back.
- ☐ Because of my back, 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, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because on my back.

Pain Scale:

Rate the severity of your pain by checking one box on the following scale

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which 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 describes your problem.

SECTION 1 – PAIN INTENSITY
☐ The pain comes and goes and is 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 comes and goes and is severe
☐ The pain is severe and does not vary much

SECTION 2 – PERSONAL CARE
☐ I would have to change my way of washing or dressing in order to avoid pain
☐ I do not normally change my way or 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 (eg. on a table)
☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently placed
☐ I can only lift very light weights at the most

SECTION 4 – WALKING
☐ I have no pain on walking
☐ I have some pain on walking but it doesn't increase with distance
☐ I cannot walk more than 1 km without increasing pain
☐ I cannot walk more than ½ km without increasing pain
☐ I cannot walk more than ¼ km 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 favorite chair as long as I like
☐ Pain prevents me from sitting more than 1 hour
☐ Pain prevents me from sitting more than 30 mins
☐ Pain prevents me from sitting more than 10 mins
☐ 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 1 hour without increasing pain
☐ I cannot stand for longer than 30 mins without increasing pain
☐ I cannot sand for longer than 10 mins without increasing pain
☐ I avoid standing because it increases the pain straight away

SECTION 7 – TRAVELLING
☐ I get no pain whilst travelling
☐ I get some pain whilst travelling but none of my usual forms of travel make it any worse
☐ I get extra pain whilst travelling but it does not compel me to seek alternative forms of travel
☐ I get extra pain whilst traveling which compels me to seek alternative forms of travel
☐ Pain restricts all forms of travel
☐ Pain prevents all forms of travel except that done ling down

SECTION 8 – 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 at all

SECTION 9 – 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 (eg dancing, hiking, ect)
☐ Pain has restricted my social life and I don't go out very often
☐ Pain has restricted my social life to my home
☐ I have hardly any social life because of the pain

SECTION 10 – CHANGING DEGREE OF PAIN
☐ My pain is rapidly getting better
☐ My pain fluctuates but overall is definitely getting better
☐ My pain is getting better but improvement is slow at present
☐ My pain is neither getting better or worse
☐ My pain is gradually worsening
☐ My pain is rapidly worsening

Pain Scale:

Rate the severity of your pain by checking one box on the following scale

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

NECK PAIN AND DISABILITY INDEX (VERNON-MIOR)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which 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 describes your 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
☐ 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 an 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 placed
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weight if they are conveniently placed
☐ 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 to with no pain in my neck
☐ I can read as much as I want to 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 neck pain
☐ 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 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 concentrating when I want to
☐ I have a great deal of difficulty in concentrating 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 neck pain
☐ I can't drive my car as long as I want due to moderate neck pain
☐ 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 1 hour sleepless)
☐ My sleep is mildly disturbed (1-2 hours sleepless)
☐ My sleep is moderately disturbed (2-3 hours sleepless)
☐ My sleep is greatly disturbed (3-5 hours sleepless)
☐ My sleep is completely disturbed (5-7 hours sleepless)

SECTION 10 – RECREATION
☐ I am able to engage in all recreation activities with no neck pain
☐ I am able to engage in all 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 neck pain
☐ I am able to engage in a few of my usual recreational activities because on neck pain
☐ I can hardly do any recreational activities because of neck pain
☐ I can't do any recreational activities at all

Pain Scale:

Rate the severity of your pain by checking one box on the following scale

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain