Kinetic Health

Soft-Tissue and Sports Improvement Systems
Bay #10 – 34 Edgedale Drive NW
Calgary, Alberta
T3A-2R4

Phone:
403-241-3772

Fax:
403-241-3846

Email:
kinetichealth@shaw.ca

Websites:
www.kinetichealth.ca
www.activerelease.ca
www.releaseyourbody.com

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?

In this Report:

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Describe the Accident

☐ 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?

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	☐ Back left
☐ Front middle	☐ Back middle
☐ Front right	☐ 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.

Striking Vehicle – check the correct options

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

What was the **size** 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 _____

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.

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 ☐ To the left
☐ Looking down ☐ To the right
☐ Looking up

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

Facts about the Patient *AFTER* the MVA Accident

Identify Areas of Pain

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

Ankle Pain	☐ YES	☐ NO
Arm Pain or Weakness	☐ YES	☐ NO
Back Pain	☐ YES	☐ NO
Elbow Pain	☐ YES	☐ NO
Fatigue	☐ YES	☐ NO
Foot Pain	☐ YES	☐ NO
Hand Pain	☐ YES	☐ NO
Headaches	☐ YES	☐ NO
Hip Pain	☐ YES	☐ NO
Knee Pain	☐ YES	☐ NO
Jaw Pain	☐ YES	☐ NO
Neck Pain	☐ YES	☐ NO
Shoulder Pain	☐ YES	☐ NO
Wrist Pain	☐ YES	☐ NO
OTHER	☐ YES	☐ NO

Describe any other areas of pain:

Emotional Reactions

Since the accident, have you noticed any of the following emotional reactions?

Crying for no apparent reason	☐ YES	☐ NO
Feeling anxious	☐ YES	☐ NO
Feeling depressed	☐ YES	☐ NO
Intolerance of bright lights	☐ YES	☐ NO
Intolerance of loud noises	☐ YES	☐ NO
Irritability, feeling frustrated	☐ YES	☐ NO
OTHER	☐ YES	☐ NO

Other Effects

Since the accident, have you noticed any of the following effects?

Dizziness or spinning sensation	☐ YES	☐ NO
Easily tired	☐ YES	☐ NO
Fatigue	☐ YES	☐ NO
Lack of awareness of surroundings	☐ YES	☐ NO
Light-headedness	☐ YES	☐ NO
Memory problems	☐ YES	☐ NO
Nausea or vomiting	☐ YES	☐ NO
Poor concentration	☐ YES	☐ NO
Problems sleeping	☐ YES	☐ NO
Ringing in the ears	☐ YES	☐ NO
Visual Disturbances	☐ YES	☐ NO

Previous History of Your OTHER 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 - Oswestry Disability Index.

A →Provide Date & Location of previous MVA

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**

B→ Provide Date & Location of previous MVA

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**

C→ Provide Date & Location of previous MVA

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**

Oswestry Disability Index

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 but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but can manage most of my personal care.
- ☐ I need help every day, in most aspects of my personal care.
- ☐ I need help every day, in most aspects of self-care.
- ☐ I do not get dressed by myself, can 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 (i.e. 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 only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ¼ of a mile.
- ☐ Pain prevents me walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ an hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain, I have less than 6 hours sleep.
- ☐ Because of pain, I have less than 4 hours sleep.
- ☐ Because of pain, I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Sex life

(if applicable)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9 – Social Life

- ☐ My social life is normal and causes me no extra 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, i.e. sports.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted social life to my home.
- ☐ I have no social life because of pain.

Section 10 – Traveling

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives extra pain.
- ☐ Pain is bad but I manage journeys of over two hours.
- ☐ Pain restricts me to short necessary journeys of under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- ☐ NO
- ☐ YES

  (If YES, please state the type of treatment you have received)

Neck Disability Index

This section has been designed to give your doctor information about how your neck pain has affected your ability to manage your daily-living tasks. Please answer every section, and mark only ONE box that applies to you, within each section. We realize you may consider that two of the statements in any one section relate to you, but please just mark the single box which most closely describes your problem. Use the following index to rate your pain:

Section 1 – Pain Intensity

- ☐ I have no pain at the moment. (0)
- ☐ The pain is very mild at the moment. (1)
- ☐ The pain is moderate at the moment. (2)
- ☐ The pain is fairly severe at the moment. (3)
- ☐ The pain is very severe at the moment. (4)
- ☐ The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care
(Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain. (0)
- ☐ I can look after myself normally but it causes extra pain. (1)
- ☐ It is painful to look after myself and I am slow and careful. (2)
- ☐ I need some help but manage most of my personal care. (3)
- ☐ I need help every day in most aspects of self-care. (4)
- ☐ I do not get dressed; I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain. (0)
- ☐ I can lift heavy weights but it gives extra pain. (1)
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)

Section 3 – Lifting *(continued)*

- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- ☐ I can lift very light weights. (4)
- ☐ I cannot lift or carry anything at all. (5)

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck. (0)
- ☐ I can read as much as I want to with slight pain in my neck. (1)
- ☐ I can read as much as I want with moderate pain in my neck. (2)
- ☐ I cannot read as much as I want because of moderate pain in my neck. (3)
- ☐ I can hardly read at all because of severe pain in my neck. (4)
- ☐ I cannot read at all. (5)

Section 5 – Headaches

- ☐ I have no headaches at all. (0)
- ☐ I have slight headaches that come infrequently. (1)
- ☐ I have moderate headaches which come infrequently. (2)
- ☐ I have moderate headaches which come frequently. (3)
- ☐ I have severe headaches which come frequently. (4)
- ☐ I have headaches almost all the time. (5)

Section 6 - Concentration

- ☐ I can concentrate fully when I want to with no difficulty. (0)
- ☐ I can concentrate fully when I want to with slight difficulty. (1)
- ☐ I have a fair degree of difficulty in concentrating when I want to. (2)
- ☐ I have a lot of difficulty in concentrating when I want to. (3)
- ☐ I have a great deal of difficulty in concentrating when I want to. (4)
- ☐ I cannot concentrate at all. (5)

Section 7 - Work

- ☐ I can do as much work as I want to. (0)
- ☐ I can do my usual work, but no more. (1)
- ☐ I can do most of my usual work, but no more. (2)
- ☐ I cannot do my usual work. (3)
- ☐ I can hardly do any work at all. (4)
- ☐ I cannot do any work at all. (5)

Section 8 - Driving

- ☐ I can drive my car without any neck pain. (0)
- ☐ I can drive my car as long as I want with slight pain in my neck. (1)
- ☐ I can drive my car as long as I want with moderate pain in my neck. (2)
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- ☐ I can hardly drive at all because of severe pain in my neck. (4)
- ☐ I cannot drive my car at all. (5)

Section 9 - Sleeping

- ☐ I have no trouble sleeping. (0)
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- ☐ My sleep is mildly disturbed (1-2 hours sleepless). (2)
- ☐ My sleep is moderately disturbed (2-3 hours sleepless). (3)
- ☐ My sleep is greatly disturbed (3-5 hours sleepless). (4)
- ☐ My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 - Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all. (0)
- ☐ I am able to engage in all my recreational activities, with some pain in my neck. (1)
- ☐ I am able to engage in most, but not all, of my recreational activities due to pain in my neck. (2)
- ☐ I am able to engage in a few of my usual recreational activities due to pain in my neck. (3)
- ☐ I can hardly do any recreational activities because of pain in my neck. (4)
- ☐ I cannot do any recreational activities at all. (5)

Patient's Total Score: _____

0-4	No disability
5-14	Mild disability
15-24	Moderate disability
25-34	Severe disability
> 35	Complete disability

Kinetic Health

Clinic Information

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8:00 AM to 6:30 PM	8:00 AM to 5:00 PM	8:00 AM to 7:00 PM	8:00 AM to 7:00 PM	8:00 AM to 5:00 PM	10:00 AM to 2:00 PM	Closed

Note: Clinic will be 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