

ASSOCIATE PROFESSOR GREG BAIN

MOTOR VEHICLE ACCIDENT AND PUBLIC LIABILITY PATIENT INFORMATION SHEET

DR / MR / MST

MRS / MISS / MS

(SURNAME)

(GIVEN NAMES)

ADDRESS

POST CODE

DATE OF BIRTH

TELEPHONE NO: (Home)

(Mobile)

(Work)

(Email)

FAMILY DOCTOR'S NAME AND ADDRESS

IS THIS A THIRD PARTY / INSURANCE CLAIM?

YES / NO

EMPLOYER

SOLICITOR'S NAME AND ADDRESS

NAME AND ADDRESS OF INSURANCE AGENT

CLAIM NO

1. Age

Occupation

2. Date, time and location of accident:

3. Brief description of the event:

4. Were you wearing a seatbelt / helmet

Yes

No

5. Brief description of damage to vehicle:

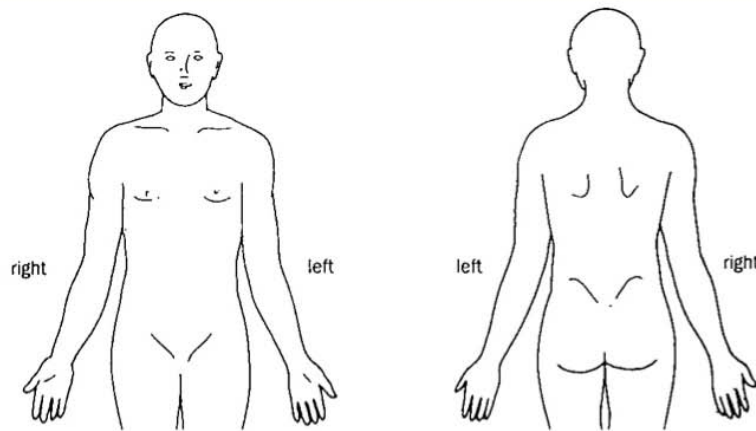
6. Did you have pain immediately Yes No
7. Were you able to get out of the car Yes No
8. Did you have any of these problems before this accident Yes No

9. What were the initial effects of the accident to you:

10. What / when treatment did you seek (eg Ambulance, GP, Physio etc):

11. Description of injury or injuries (please use diagram to indicate where you feel pain – please include ALL affected areas)

Please mark on the diagram the site of pain. Also mark your worst pain with an 'x' mark any numbness with an 'o'



12. Treatment sought ie anti-inflammatory tablets, chiropractic care, physio, massage, injections, splints, xrays, MRI, blood tests etc (include names of Practitioners):

13. Impact on capacity to work (work duties, hours):

14. Impact on daily activities ie home/sport/social life etc:

Information on this form may be used in correspondence, medical reports, court hearings etc.