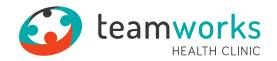
Date:



Name:

## ICBC Initial Questionnaire

Care Card No.:		Claim Number:					Date of Injury:
Adjustor's Name:						Adjustor's Phone No.:	
Lawyers Name (if applic.):						Lawyer's Phone No.:	
I consent to Teamworks Health Clinic communicating with m							
1	Location of Injury	Yes No Des				Desc	cription of pain/symptoms
	Do you have neck pain?			•			
	Do you have mid back pain?			•			
	Do you have low back pain?						
	Any other symptoms?			•			
2	When did you first get examined?						
3	Who examined you? (Family doctor, hospital, etc.)						
4	Describe how you were injured						
5	Were there any x-rays taken (or other imaging)?		Yes		No		
	If yes, where were they taken?						
	When were they taken?						
	What area of the body?						
	What were the results?						
6	Have you continued work since the injury?		Yes		No		from what date you been off work?
7	Have you ever had symptoms or received treatment for the area(s) injured in this accident?		Yes		No	_	·
	If yes, please describe: Past incident: Treatment:		Date:				
Statement of Understanding							
I understand that Teamworks Health Clinic has a 24-hour cancellation policy and that I will be charged the <b>full private cost</b>							
for a missed appointment or a short notice cancellation.							
Signature:							