teamworks HEALTH CLINIC

PHYSIOTHERAPY
MASSAGE THERAPY
ACUPUNCTURE
CHIROPRACTIC
DIETETICS
AND MORE

ICBC Initial Questionnaire

Name:		Date:
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 my lawyer about my case		

1	Location of Injury	Yes	No	Description 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	If not, from what date have 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: Date: Past incident: Treatment:			

Statement of Understanding

I understand that Teamworks Health Clinic has a 24-hour cancellation policy and that I will be charged the **full private cost** for a missed appointment or a short notice cancellation.

Signature: _____

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