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 _____

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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***

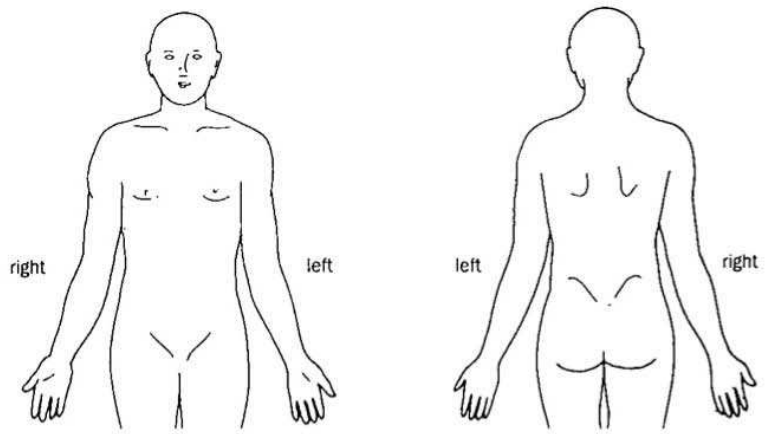
8. **Did you have any of these problems before this accident** ***Yes*** ***No***

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.