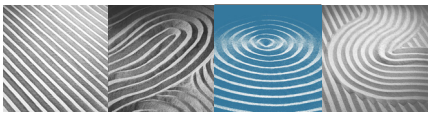

INJURY CLAIM UPDATE FORM

Date of Accident: _____ Client Name: _____

Client File Number: _____ Date of this update: _____

PLEASE COMPLETE ALL OF THE QUESTIONS THAT ARE RELEVANT TO YOU!

Current Symptoms:

What symptoms are you still having from the injuries sustained in the accident?

Headaches	☐ yes	☐ no	Number of Days per week _____	On a scale of 1(good) - 10(bad)	_____
Neck Pain	☐ yes	☐ no	_____		_____
Shoulder Pain	☐ yes	☐ no	_____		_____
Arm Pain	☐ yes	☐ no	_____		_____
Leg Pain	☐ yes	☐ no	_____		_____
Back Pain	☐ yes	☐ no	_____		_____

Other_____

_____

_____

Medication: List all medication taken *as a result of the accident* since the last update completed:

_____

_____

Treatment: List the full name, address and telephone number of *every* physician, surgeon, physiotherapist, chiropractor, massage therapist, etc. who has examined or treated you for your injuries as a result of the accident:

Name: _____ Type of Practice _____

Address: _____

Telephone number: (____)_____

Diagnosis or Explanation offered: _____

Dates of Appointments: _____

Name: _____ Type of Practice _____

Address: _____

Telephone number: (____)_____

Diagnosis or Explanation offered: _____

Dates of Appointments: _____

Name: _____ Type of Practice _____

Address: _____

Telephone number: (____)_____

Diagnosis or Explanation offered: _____

Dates of Appointments: _____

Name: _____ Type of Practice _____

Address: _____

Telephone number: (____)_____

Diagnosis or Explanation offered: _____

Dates of Appointments: _____

PLEASE LIST ADDITIONAL PRACTITIONERS ON THE BACK OF THIS PAGE

Wage Loss Are you still off work as a result of the accident? ☐ yes ☐ no

What date did you return to work? Part Time _____

Full Time _____

Independent Medical Examinations Has your insurance company said anything about sending you to see a doctor to comment on your eligibility for benefits? ☐ yes ☐ no
Please describe: _____

_____

Section B Benefits

Has your automobile insurer been paying your:

Disability benefits	☐ yes ☐ no	(when off work - totally disabled)
Prescriptions	☐ yes ☐ no	
Physiotherapy	☐ yes ☐ no	
Chiropractic	☐ yes ☐ no	
Massage	☐ yes ☐ no	
Other	☐ yes ☐ no	

Other Benefits:

Do you have:	☐ yes ☐ no	Blue Cross
	☐ yes ☐ no	Other Benefit Provider (GWL, Manulife, etc.)

If so, has your benefits provider been reimbursing you for:

Disability	☐ yes ☐ no
Prescriptions	☐ yes ☐ no
Treatment	☐ yes ☐ no

Other Is there anything else you think we should know about that happened since the last update form was completed?_____

_____

_____

_____

_____

Dated this ____ day of _____, 200__ _____

Client's Signature