Aurora Integrative Medical

AIM
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Medical

ICBC Intake Questionnaire

Name: _____ _____ _____
(First) (Last) (Middle)

Date of MVA: _____

Claim Number: _____ Claim Office: _____

ICBC Adjustor's Name: _____ M.S.P Number: _____

Date of Birth: (Month): _____ (Day):_____ (Year): _____ Age: _____ Sex: _____

Phone Number: _____ Email: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Occupation: _____ Hours per week: _____ Employer: _____

Emergency Contact Name: _____ Phone: _____
Emergency Contact Relationship to you: _____

Are you under the care of another primary care physician? (eg. MD, ND, Specialist)? Yes No

Name of Doctor/Clinic: _____ Phone Number: _____

Have you had previous Chiropractic care before? Yes c No c If YES, who? _____
Type of Injury: _____ Date of Last Treatment: _____

How did you hear about Aurora Integrative Medical? Please circle:
Internet Search Friend Family Newspaper Other (please specify): _____

Please complete this questionnaire with care, as this will help us determine the most effective treatment plan for you.

4212 Dawson Street, Burnaby BC, V5C 0B8 | P: 604-558-2288
Email: dramber@auroramed.ca| Visit: www.AuroraIntegrative.com

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What are your **main reason(s)** for coming in? _____
_____
_____

Please list **diagnoses** and types of **treatments** you have received: _____
_____
_____

Please list any **medications** you were taking prior to the accident, or are **presently** taking with doses and the date you started taking them:
_____
_____

Please list any **supplements**, remedies, and herbal medicines you are taking (include brands & dosages if known): _____
_____
_____

Please indicate the occurrence of the following, with brief details and dates:

- Accidents _____
- Hospitalizations _____
- Surgeries _____
- Major illness _____
- Traumatic event _____

On a pain scale from 1-10 (1= no pain, 10=severe pain), how would you rate your current level of discomfort?_____

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