



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	<input type="checkbox"/> yes	<input type="checkbox"/> no	Number of Days per week _____	On a scale of 1(good) - 10(bad)	_____
Neck Pain	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____		_____
Shoulder Pain	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____		_____
Arm Pain	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____		_____
Leg Pain	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____		_____
Back Pain	<input type="checkbox"/> yes	<input type="checkbox"/> 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