PORT COQUITLAM
THERAPEUTIC
MASSAGE CLINIC

2248 Elgin Ave Suite 106
Port Coquitlam, BC
V3C 2B2
Phone: 604 945 9401

FORM 4 - MASSAGE THERAPY ICBC INTAKE FORM

Name: _____ Date: _____

ICBC Claim #: _____ Date of Accident: _____

ICBC Adjuster: _____ Adjuster Phone #: _____

Referring Doctor: _____

Lawyer's Name: _____

Lawyer's Address: _____

ACCIDENT DETAILS

Please circle your response:

☐ Y ☐ N Were you driving?

If no,

☐ Y ☐ N Were you a passenger?

Front or Rear? ▼ If Rear - Left, Right, Middle? select - ▼

☐ Y ☐ N Were seat belts worn?

Was your vehicle:? ☐ Stopped ☐ Moving ☐ Turning Left or Right

Please describe: _____

_____

☐ Y ☐ N Did you anticipate being hit?

Upon impact, which way were you thrown: _____

☐ Y ☐ N Upon impact, was there a blinding or exploding sensation in your head?

Immediately after the accident, which areas of your body hurt?

_____

☐ Y ☐ N Could you move all the parts of your body?

If no, please describe: _____

☐ Y ☐ N Was an ambulance called?

☐ Y ☐ N Did you go to the hospital?

☐ Y ☐ N Have you had any x-rays taken?

If so, where? _____

What discomfort did you have the first evening following the accident?

_____

PORT COQUITLAM
THERAPEUTIC
MASSAGE CLINIC

Were you able to sleep the first evening: ☐ Y ☐ N

What discomfort did you have the following day?: _____

Please check all that apply. Complaints of the following:

_____ Eyes	_____ Ears	_____ Faces
_____ Dizziness	_____ Sweating	_____ Headaches
_____ Difficulty swallowing	_____ Nasal Disturbances	_____ Chest Disturbances
_____ Unconsciousness	_____ Can't Sleep	_____ Restlessness
_____ Inability to Void		

Symptoms in the arms or legs:

	Arms	**Legs**
Numbness	_____	_____
Tingling	_____	_____
Difficulty in Moving	_____	_____
Loss of Strength	_____	_____

On the scale below, mark you discomfort level at this time:

v2b5 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ v2b6

Absolutely No Pain — Worst Pain of my Life

Patient information / Agreement

I, _____ (print your name) understand that ICBC's policy for massage therapy coverage is as follows: ICBC will pay the therapist directly for a portion of the treatment charge, the amount of treatments covered is up to your adjuster and is different for every patient. There is an initial user fee of $55.00 for the first visit and $30.00 for subsequent visits. If, for any reason, ICBC refuses payment of any massage therapy visits, it is understood that the patient is responsible for the entire treatment charge.

I, _____ (print your name) verify that all the information contained in this accident information sheet to be accurate. I also understand that any information provided by myself is confidential. There will be no release of patient information without my prior written authorization.

****PLEASE TAKE INTO ACCOUNT THAT YOUR MASSAGE THERAPY SESSION WILL INCLUDE AN ASSESSMENT AND TIME FOR PREPARATION OF THE TREATMENT****

Patient Signature: _____ (or guardian if under 18) Date: _____