# PERSONAL INJURY WORKSHEET

A. PERSONAL Date completed: ____________

1. IDENTIFICATION

Full Legal Name: ____________

Address: ____________

____________

City | Province | Postal code

Phone numbers: ____________

Home | Cell | Work

Fax numbers: ____________

Home | Work | Other

Email ____________

Personal | Work | Other

Next of Kin/Contact Person: ____________

Phone numbers: ____________

Home | Cell | Work

Birthdate: ____________ SIN: ____________

Alberta Health Number: ____________ Prior/other Health Numbers: ____________

Blue Cross Number: ____________ Other Insurance Number: ____________

Disability Insurer: ____________ Address ____________

Claim/ policy No.: ____________ Adjustor ____________

Who's the primary name on any other Health plans: ____________

Birthdate of the primary person on other Health plans: ____________

Which Health plan: ____________

2. FAMILY DETAILS: ____________

Spouse's Name ____________

Spouse's birthdate ____________

Spouse's Phone Numbers: ____________

Home | Cell | Work

Spouse's Email: ____________

Child's Name ____________

Child's Birthdate: ____________

Child's Name ____________

Child's Birthdate: ____________

Child's Name ____________

Child's Birthdate: ____________

3. EMPLOYMENT DETAILS:

Your Employer ____________

Employer's Address ____________

____________

City | Province | Postal Code

How Long there: ____________ Hours of Work: ____________

Description of Work: ____________

____________

Present Salary: ____________ Supervisor ____________

Please give us a copy of your resume, if you have one available.

B. MEDICAL

4. What injuries did you suffer in this accident?

5. Hospitalization:

Name of Hospital ____ Length of Stay: ____

Treating Doctors

Treatment Received

Name of Hospital ____ Length of Stay: ____

Treating Doctors

Treatment Received

6. Medical Doctor: (use extra sheets if necessary)

Name:

Address:

City Province Postal Code

Office Phone Number: ____ Office Fax Number: ____

What treatment was prescribed by your doctor? (after your release from the hospital)

Name:

Address:

City Province Postal Code

Office Phone Number: ____ Office Fax Number: ____

What treatment was prescribed by your Doctor? (after your release from the hospital)

Name:

Address:

City Province Postal Code

Office Phone Number: ____ Office Fax Number: ____

What treatment was prescribed by your Doctor? (after your release from the hospital)

Name:

Address:

City Province Postal Code

Office Phone Number: ____________________ Office Fax Number: ____________________

What treatment was prescribed by your Doctor? (after your release from the hospital)

7. Medications: (attach receipts or copies of prescriptions, if possible)

Name of Drug: ____________ Who Prescribed: ____________ Length of time utilized: ____________

Name of Drug: ____________ Who Prescribed: ____________ Length of time utilized: ____________

Name of Drug: ____________ Who Prescribed: ____________ Length of time utilized: ____________

Name of Drug: ____________ Who Prescribed: ____________ Length of time utilized: ____________

Name of Drug: ____________ Who Prescribed: ____________ Length of time utilized: ____________

8. Physiotherapy:

Name:

Address:

City Province Postal Code

Office Phone Number: ____________________ Office Fax Number: ____________________

What treatment was prescribed?

Name:

Address:

City Province Postal Code

Office Phone Number: ____________________ Office Fax Number: ____________________

What treatment was prescribed?

9. Chiropractor:

Name:

Address:

City Province Postal Code

Office Phone Number: ____________________ Office Fax Number: ____________________

What treatment was prescribed?

Name:

Address:

City Province Postal Code

Office Phone Number: ____________________ Office Fax Number: ____________________

What treatment was prescribed?

10. Massage Therapist:
Name:
Address: ______________________________

______________________________
City Province Postal Code
Office Phone Number: ____________ Office Fax Number: ____________
What treatment was prescribed?

______________________________

______________________________

Name:
Address: ______________________________

______________________________
City Province Postal Code
Office Phone Number: ____________ Office Fax Number: ____________
What treatment was prescribed?

______________________________

______________________________

11. Other medical treatments: (Give details – who prescribed, type of treatment, duration of treatment, costs, etc.)

______________________________

______________________________

C. DOCUMENTS WHICH WOULD ASSIST US: (Are there any? Who has them?)

12. Photos:

Of Vehicles: ____________ Of Accident Scene: ____________

13. Written Statements:

______________________________

14. Appraisals/Estimates

______________________________

15. Other

______________________________

D. OPTIONAL INFORMATION

16. OUT-OF-POCKET-EXPENSES:
See attached worksheet

E. INSURANCE PAYMENTS RECEIVED

17. SECTION B (no-fault income payments)

Insurer Paying Claim Number
Adjuster
Time Period Involved Amount Paid to date $

18. Have you received payments from any other source?

Insurer paying Claim Number
Adjuster
Time Period Involved Amount paid to date $
Insurer paying Claim Number
Adjuster
Time Period Involved Amount paid to date $

19. To what extent did you contribute to any of the Planes referred to above (e.g. is some money deducted from your cheque each pay period?) if possible, provide a copy ofhte Benefit Book concerning any of the above

Plans

20. PAYMENTS FROM OTHER SOURCES (e.g. E.I., C.P.P., W.C.B., Social Services)

Insurer Paying Claim Number

Address:

City Province Postal Code

Adjuster/Contact Person

Time Period of payment Amount Paid to date $

Insurer Paying Claim Number

Address:

City Province Postal Code

Adjuster/Contact Person

Time Period of payment Amount Paid to date $

F. ACCIDENT DESCRIPTION

21. Describe how the accident occurred. Draw a diagram if you wish: (use extra sheets if necessary)

Date: Time:

22. Particulars of Vehicle #1 (the vehicle that you were in):

Year Make Colour License No. V.I.N.

Driver Vehicle #1

Name:

Address:

City Province Postal Code

Phone numbers:

Home Cell Work

Owner Vehicle #1

Name:

Address:

City Province Postal Code

Insurance Company

Address:

City Province Postal Code

Policy Number: Contact Person:

Email:

Direct Line Fax

23. Particulars of Vehicle #2 (the other vehicle):

Driver Vehicle #2

Name:

Address:

| City | Province | Postal Code |
|---|---|---|

Phone numbers:

| Home | Cell | Work |
|---|---|---|

Owner Vehicle #2

Name:

Address:

| City | Province | Postal Code |
|---|---|---|

Phone numbers:

| Home | Cell | Work |
|---|---|---|

Insurance Company

Address:

| City | Province | Postal Code |
|---|---|---|

Policy Number: Contact Person:

Email:

Direct Line Fax

24. Specifics:

Where were you seated?

Were you wearing your seatbelt?

If not, why not?

Had anyone consumed any alcohol or drugs? (Explain)

25. Passengers in vehicles:

Name

Address

| City | Province | Postal Code |
|---|---|---|

Phone numbers:

| Home | Cell | Work |
|---|---|---|

Name

Address

| City | Province | Postal Code |
|---|---|---|

Phone numbers:

| Home | Cell | Work |
|---|---|---|

Name

Address

| City | Province | Postal Code |
|---|---|---|

Phone numbers:

| Home | Cell | Work |
|---|---|---|

26. Witnesses to the accident:

Name

Address

City Province Postal Code

Name

Address

City Province Postal Code

Name

Address

City Province Postal Code