Personal Injury Workbook

To assist you in recording relevant information
PERSONAL INJURY WORKBOOK

This workbook will help you keep track of important information about your accident and injuries. As you progress through the claims process you will often be asked to provide personal information or details about the accident. It is a good idea to start tracking and recording this information now, so it can be easily remembered and accessible if needed.

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Personal Information

Name: 
Address: 
Telephone/fax: 
Date of birth: 
OHIP no.: 
Driver’s license no.: 
SIN no.: 
Citizenship status: 

Details of Accident

Date: 
Time: 
Location: 
Description of accident: 

Did the accident happen while you were working? 

Were the police called?

Who was the investigating officer? 
Did you give a statement? 
Do you have a copy? 
If this was a motor vehicle accident, do you have a copy of the accident report? 
Was anybody charged by the police? 
If yes, provide details: 

Was an ambulance called? ________________________________

If this was a motor vehicle accident, list all of the other vehicles and drivers involved:

____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________

Was anyone else injured? ______________________________

Were there any witnesses? _____________________________

Names and contact information:

____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________

Did you report the accident? __________________________

If yes, when and to whom? _____________________________

____________________________________________________
____________________________________________________
____________________________________________________

Was a report made? ________________________________

Do you have a copy? ________________________________

Family Information

Marital status: ________________________________

Spouse’s/common-law partner’s name, address, phone number, and date of birth: ________________________________

____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________

Date of marriage/separation/divorce: ________________________________
Do you have any children? __________________________________________________________
   If yes, names, addresses, phone numbers, and dates of birth:

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

Are your parents still living? ______________________________________________________
   If yes, names, addresses, phone numbers, and dates of birth:

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

Do you have any siblings? _________________________________________________________
   If yes, names, addresses, phone numbers, and dates of birth:

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

Do you have any living grandparents or grandchildren? ________________________________
   If yes, names, addresses, phone numbers, and dates of birth:

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
Medical Information

Did you go to the hospital after your accident? ____________________________
If yes, which hospital and when? ____________________________
What treatment did you receive? ____________________________

Which doctors did you see? ____________________________

Did you go to see your family doctor or a walk-in clinic after the accident? ______
If yes, when and which doctor? ____________________________
If this was your family doctor, how long have you been his/her patient?
What treatment did you receive? ____________________________

Have you been referred to any specialists since your accident? ________________
If yes, who and when? ____________________________
What treatment did you receive? _______________________________________

____________________________________

____________________________________

____________________________________

____________________________________

Have you seen a chiropractor, physiotherapist, massage therapist, psychiatrist, psychologist or other treatment provider since the accident? ____________________________

If yes, list all providers and the times you saw them: ____________________________

____________________________________

____________________________________

____________________________________

____________________________________

Describe the treatment you received: ____________________________

____________________________________

____________________________________

____________________________________

____________________________________

List your injuries as you know them: ____________________________

____________________________________

____________________________________

____________________________________

____________________________________

Describe the effects your injuries have on you, including the frequency and severity of your symptoms:

____________________________________

____________________________________

____________________________________

____________________________________

____________________________________
List any past injuries you have suffered for which you sought medical attention:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Have you taken any medication since your accident? ____________________________
List all medications and how long you took them: ____________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Have you undergone any medical testing, such as X-rays, MRIs, CAT scans, etc.?
__________________________________________________________________________
If yes, provide details: _____________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Were any other members of your family injured in the accident? ______________
If yes, provide details: _____________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Employment Information

Were you employed at the time of the accident? ____________________________________________

Name of employer: ________________________________________________________________

Address: __________________________________________________________________________

Nature of business: __________________________________________________________________

Job title and description: _______________________________________________________________________

____________________________________________________________________________________

Supervisor’s name: ____________________________________________________________________

If you are a member of a union, identify union and local: ________________________________

____________________________________________________________________________________

Hours worked per week: __________________________________________________________________

Hourly wage, if applicable: ____________________________________________________________________

Average overtime worked, if any: ____________________________________________________________________

Overtime rate, if applicable: ____________________________________________________________________

Length of time with that employer: ____________________________________________________________________

Income for the past 52 weeks before the accident: ____________________________________________________________________

Income for the past 4 weeks before the accident: ____________________________________________________________________

Did you miss any time from work as a result of your injury? _____________________________

If yes, provide details: ____________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Did you use up any sick leave? ______________________________________________________

If yes, provide details: _____________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
Did you use any vacation time? ____________________________________________
If yes, provide details: __________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

Were you able to return to work? ________________________________
If yes, provide details: ____________________________________________

__________________________________________________________

__________________________________________________________

Describe your essential job duties: ________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

Which duties does your injury prevent you from performing? ____________

__________________________________________________________

__________________________________________________________

__________________________________________________________

Were you self-employed at the time of the accident? _________________

Name of business: ________________________________________________
Address: _________________________________________________________

__________________________________________________________

Nature of business: _______________________________________________
Ownership interest: ____________________________
Corporation/partnership/sole proprietorship: ________________________
Does your business have a bookkeeper/accountant? __________________________
Contact information: ______________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
Income for the last fiscal year before the accident: __________________________
Income for the past 52 weeks before the accident: __________________________
Did you miss any time from work as a result of your injury? _________________
If yes, provide details: __________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
Did your business lose income while you were off work? _________________
If yes, provide details: __________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
Did your business have to replace you while you were off work? __________
If yes, provide details: __________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
Were you able to return to work? ________________________________
If yes, provide details: __________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
Were you the primary caregiver for a person in need of care? ____________________

If yes, for whom did you provide care? ____________________

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Name, address, date of birth: __________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Does the person suffer from a disability? ____________________

What care did you provide? ____________________

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Which duties did your injury prevent you from performing, if any?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How often did you provide that care? ____________________


Were you a student at the time of the accident? ____________________

If yes, which school/program: ____________________

________________________________________________________________________
________________________________________________________________________

Did you miss any time away from your schooling? ____________________

If yes, provide details: ____________________

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Education

Have you graduated from school? ________________________________

If yes, which school, where, when? ________________________________

______________________________________________________________

______________________________________________________________

Have you attended college or university? _________________________

If yes, which school(s), where, when? _____________________________

______________________________________________________________

______________________________________________________________

Details of diploma(s) or degree(s) obtained: ______________________

______________________________________________________________

______________________________________________________________

Have you received any special training? __________________________

If yes, provide details: __________________________________________

______________________________________________________________

______________________________________________________________

Attendant Care and Housekeeping Assistance

Has your injury prevented you from being able to look after your personal hygiene?

If yes, provide details: _________________________________________

______________________________________________________________

______________________________________________________________

If yes, has someone provided you with assistance? __________________________
Name, address, telephone number: __________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Describe the care that person has provided: _________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Was that person paid for their services? _________________________________

Has your injury prevented you from performing your ordinary housekeeping and
home maintenance tasks around the home? ________________________________

If yes, provide details: ____________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

If yes, has someone else provided you with assistance? ______________________
Name, address, telephone number: ________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Describe the work that person has done: _________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Was that person paid for their work? ________________________________
Recreational Activities

List all of the recreational activities, sports, or hobbies that you engaged in prior to the accident, and describe how often you would engage in them.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Which activities does your injury prevent you from enjoying, if any?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Insurance Information

Automobile Insurance

Do you, your spouse, a member of your family, or your employer own a vehicle?

________________________________________________________________________________________

List the insurance companies that insure these vehicles: ________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Short-Term Disability

Do you have a short-term disability insurance policy available to you, either privately or through your work? ________________________________

List the applicable insurance companies: ________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
Long-Term Disability
Do you have a long-term disability insurance policy available to you, either privately or through your work? ______________________________
List the applicable insurance companies: ______________________________
____________________________________
____________________________________

Medical Insurance
Do you, your spouse, or another member of your family, have additional medical coverage available to you, either privately or through your work?

List the applicable insurance companies: ______________________________
____________________________________
____________________________________
____________________________________

Life Insurance
If a family member has died as a result of an accident, did that family member have a life insurance policy?
List the applicable insurance companies: ______________________________
____________________________________
____________________________________
____________________________________
List any insurance brokers that you have dealt with concerning insurance policies: ______________________________
____________________________________
____________________________________
____________________________________

Have you applied for and/or received Worker’s Safety and Insurance Board benefits, Canada Pension Plan benefits, Ontario Disability Support Program benefits, or any other benefits either before or after your accident?
If yes, provide details: ________________________________

_________________________________________________

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Claim Information

List the insurance companies that you have reported your accident to:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

When and how did you report the accident? _________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Have you been contacted by adjusters for these insurance companies? ______

If yes, list the adjusters that have contacted you, their contact information, and their claim number(s):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Have you provided a statement to one of these adjusters? _________________

If yes, provide details: _________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Do you have a copy of the statement? _____________________________________

Have you notified another party of your accident? _________________________

If yes, provide details: _________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Have you been contacted by an insurance adjuster representing another party?

If yes, list the adjusters that have contacted you, their contact information, and their claim number(s):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Have you provided a statement to one of these adjusters? ________________

If yes, provide details:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Do you have a copy of the statement? ____________________________

Have you undergone any medical assessments at the request of any insurance adjuster? ____________________________

If yes, provide details:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Do you have a copy of any reports that were made? ____________________________

Has any party denied your claim? ____________________________

If yes, provide details:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________