AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date _____

Patient _____ No. _____

Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____

Who referred you to our office? _____

Social Sec. # _____ Business Phone _____ Company Name _____

Company Address _____

Please explain in detail how your accident happened? _____

_____

_____

Driver of other vehicle (if any) _____ Date of Birth _____

Insurance Company _____ Address _____ Phone No: _____

Policy No. _____

Claim No. _____

Name of person who has made contact with you _____

Name of driver of vehicle in which you were injured (self or other) _____

Insurance Company _____ Address _____ Phone No: _____

Policy No. _____

Claim No. _____

Name of Person who has made contact with you _____

Have you retained an attorney? ❑ Yes ❑ No ❑ Not Yet

If so, his/her name, address & phone # _____

Give time and date present injury occurred _____ ❑ AM ❑ PM ____/____/____

You were heading? ❑ North ❑ South ❑ East ❑ West on _____ (street or highway)

Number of people in your vehicle _____

Were police notified? ❑ Yes ❑ No Did head strike windshield or object? ❑ Yes ❑ No

Were you knocked unconscious ❑ Yes ❑ No If so, for how long _____

You were struck from? ❑ Behind ❑ Front ❑ Left Side ❑ Right Side

You were? ❑ Driver ❑ Passenger ❑ Front seat ❑ Back seat ❑ Using seat belts ❑ Other protective devices

Did you feel pain immediately after the accident? ❑ Yes ❑ No ❑ Later that day ❑ Next day ❑ When _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

Was treatment given? _____

Was any doctor consulted after the accident? ❑ Yes ❑ No

If so, give doctor's name _____ ❑ D.C., ❑ M.D., ❑ D.O., ❑ D.D.S. _____

Doctor's Diagnosis _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ❑ Yes ❑ No

If so, what were the complaints? _____

Before the injury, were you capable of working on an equal basis with others your age? ❑ Yes ❑ No

Are your work activities restricted as a result of this accident? ❑ Yes ❑ No

Since the injury, are your symptoms ❑ Improving? ❑ Getting worse? ❑ The same?

HEALTH QUESTIONNAIRE

Please Check Mark Each of the Conditions Below that You are Currently Experiencing

Date:_____

Patient:_____ **No.:**_____

MUSCULO SKELETAL SYSTEM

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

GENITO-URINARY SYSTEM

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

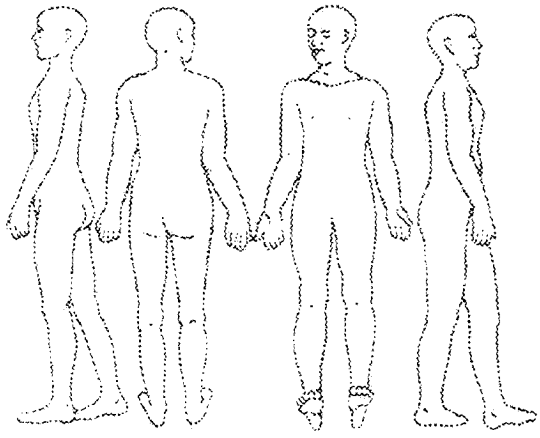
FEMALE

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

ARE YOU PREGNANT?

☐ YES ☐ NO

SYMPTOM LOCALIZATION



P ____ Pain T ____ Tender
N ____ Numb H ____ Hypoesthesia
S ____ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

GASTRO-INTESTIONAL SYSTEM

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

HABITS

- ☐ Cigarettes
- ☐ Alcohol Abuse
- ☐ Coffee or Tea
- ☐ Drug Abuse
- ☐ _____

CARDIO-VASCULAR RESPIRATORY

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

EYE, EAR, NOSE AND THROAT

- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficult breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw Pain

Patient's Signature _____

●●●●●●●●●●●●●●●●●●●●●●●●**DO NOT WRITE BELOW THIS LINE**●●●●●●●●●●●●●●●●●●●●●●●●

_____

_____

_____

Patient Accepted? ☐ **Yes** ☐ **No** **Doctor's Signature**_____

FUNCTIONAL RATING INDEX

For use with **Neck or Back Problems** only

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number that most closely describes your condition right now**.

1. Pain intensity

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly disturbed Sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No Pain; No restriction	Mild pain no restriction	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

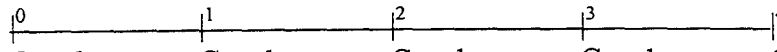
4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

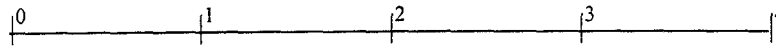
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



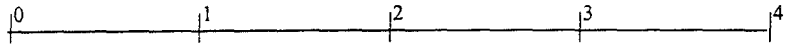
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



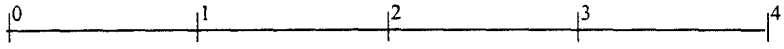
0	1	2	3	4
No pain	Occasional pain; 25% of day	Intermittent pain; 59% of day	Frequent pain; 75% of day	Constant pain

8. Lifting



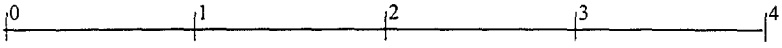
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Patient Signature **Date**