

## Motor Vehicle Accident Check List

1. Call your insurance to report the accident
2. Ask if you have PIP (Personal Injury Protection) on your policy
3. If you do not have PIP coverage, call us (577-0294)
4. Open the claim with your insurance
  - a. Get the billing address
  - b. Get a claim number
5. If you were examined in the Emergency Room or by your medical doctor, let us know in advance of your appointment so that we can get the records.

### Before your appointment you must have:

- Your paper work completed
- Your insurance information

### If possible please have the following

- A photo of the damage to the car you were in
- A copy of the police report if applicable.

## NEW PATIENT INFORMATION

Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Marital status \_\_\_\_\_

*By giving the following phone numbers I authorize the use of calls/voicemails*

*Home Phone* \_\_\_\_\_ *Work Phone* \_\_\_\_\_ *Cell Phone* \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

*Give us your e-mail If you want e-mail appointment reminders and our monthly newsletter*

*E-mail address* \_\_\_\_\_

## PARENT OR SPOUSE INFORMATION

Name \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_

**How did you find us?**  Referred by \_\_\_\_\_ medical doctor, friend, family  
 Phone book which? *Yellow book, Dex, Pdc,*  Website,  Internet,  Street Sign  Mailer  
 Other \_\_\_\_\_

## NEW OR UPDATED AUTHORIZATION FOR TELEPHONE CALLS AND OFFICE MAIL

Federal HIPAA laws allow you to restrict or change the means for the doctor and staff to communication with you or to contact you through alternative means. In order for our office to keep current with changes in addresses or telephone numbers or simply preference choices, we need your permission to contact you via telephone at your work or home, cellular telephone, pager, email, or to leave messages on your answering machine. Your agreement will allow our office to use your name and mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements/questions, status of your account, and other office related matters. **If you have a telephone number that you do not want used for messages or calls, please do not write these numbers on your intake forms.** You may indicate a new or preferred mailing address by indicating so on this form. This authorization may be revoked by you, at any time, by advising our office (privacy officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

**I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE MY CURRENT INSURANCE INFORMATION**

Signature \_\_\_\_\_ Date \_\_\_\_\_  No expiration date

Expiration Date/Event for Authorization: Date: \_\_\_\_\_  Expires When treatment/billing has concluded with our office

NAME \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

**AUTOMOBILE ACCIDENT HISTORY**

Date of Accident: \_\_\_\_\_ Claim Number \_\_\_\_\_

**THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:**

**Your Vehicle type: Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_ Vehicle size:**  
 Car  Pickup  Subcompact Car  Pickup - small  
 Van  Commercial Truck  Compact Car  Pickup - large  
 Station Wagon  Sports Utility Vehicle  Mid-size Car  Sports Utility-small  
 Other \_\_\_\_\_  Large Car  Sports Utility-large

**Your position in the vehicle:**

Driver  
 Front Passenger  Rear Passenger  Third Seat (rear)  
Passenger Location----- Driver's side  Middle  Passenger's Side

**Speed of your vehicle:**

Stopped  Accelerating  
 Parked  Moving approximately \_\_\_\_\_ miles per hour  
 Slowing

**Why Vehicle was slowed or stopped:**

Traffic Signal  Parking  
 Pedestrian  Traffic  
 Stop Sign  Busy Intersection

**Collision Type:**

Driver Side Impact  Rear and Front  
 Passenger Side Impact  Rear Impact  
 Front Impact  Pedestrian Incident

**THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:**

**Vehicle type:**  Car  Pickup  Passenger Van  Commercial Truck  Station Wagon  Sports Utility Vehicle  Other \_\_\_\_\_  
**Vehicle size:**  Subcompact Car  Pickup - small  Compact Car  Pickup-large  Mid-size Car  Sports Utility-small  Large Car  Sports Utility-large

**CONDITIONS AT THE TIME OF THE ACCIDENT:**

**Time of day:**  Full daylight  Dawn  Dusk  Night  
**Road Conditions:**  Dry  Damp  Wet  Snow covered  Ice covered  Patchy Ice/Snow  
**Visibility:**  Excellent  Good  Fair  Poor  
**Visibility compromised by:**  Brightness  Darkness  Rain  Snow  Fog  Traffic

**THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:**

**Were you...**  Totally unaware that the accident was impending  Aware that the accident was impending  Aware that the accident was impending and braced for it  
**Restraints: (check all that apply)**  Seat belt  Shoulder harness  No restraints

**If you were the driver of the vehicle, was your foot on the brake pedal?**  Yes  No  Knocked off by impact

**Was the air bag deployed?**

- Car not equipped with air bag
- Air bag deployed
- Air bag not deployed

**What position was YOUR headrest in?**

- High position-top of headrest even with top of head
- Middle position-top of headrest even with middle of neck
- Low position-top of headrest even with shoulders

**Was your vehicle pushed forward from the impact?**

- no
- yes, if yes How far was your vehicle pushed forward?
  - one car length
  - more than one car length
  - one-half car length
  - less than one-half car length

**Position of YOUR head at time of impact?**

- Facing straight ahead
- Tilted forward
- Rotated to the left
- Rotated to the right

**Was your head thrown...?**

- Backward and then forward
- Forward then backward
- To the left
- To the left then the right
- To the right
- To the right, then the left

**Position of Your body at time of impact?**

- Straight
- Tilted forward
- Rotated to the left
- Rotated to the right

**Was your body thrown...?**

- Backward and then forward
- Forward then backward
- To the left
- To the left then the right
- To the right
- To the right, then the left

**Damage to vehicle YOU were in:**

- Incurred minimal damage-\$\_\_\_\_\_
- Incurred moderate damage \$\_\_\_\_\_
- Incurred severe damage \$\_\_\_\_\_
- Was totaled \$\_\_\_\_\_
- Not known

**Citations:**

- None issued
- Yourself
- Driver of vehicle patient was a passenger of
- Driver of other vehicle
- Not sure

**AS A RESULT OF THE FORCE OF THE COLLISION WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE**

**Head**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Air bag
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front of seat
- Back of seat

**Left Arm**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Air bag
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front of seat
- Back of seat

**Torso**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Air Bag
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front of seat
- Back of seat

**Right Arm**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Air Bag
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front of seat
- Back of seat

**Right Leg**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Air Bag
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front of seat
- Back of seat

**Left Leg**

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Air Bag
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front of seat
- Back of seat

**THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:**

**Did you lose consciousness? Immediately following the accident, did you feel...?**

- |                              |                                      |                                    |
|------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Dizzy       | <input type="checkbox"/> Weak      |
| <input type="checkbox"/> No  | <input type="checkbox"/> Dazed       | <input type="checkbox"/> Nervous   |
|                              | <input type="checkbox"/> Disoriented | <input type="checkbox"/> Nauseated |

**Were you able to walk unaided?**

- Yes  
 No

**Where did you go...?**

- |  |   |
|--|---|
| <input type="checkbox"/> Drove home                      | <input type="checkbox"/> Drove to work        |
| <input type="checkbox"/> Was driven home                 | <input type="checkbox"/> Was driven to work   |
| <input type="checkbox"/> Drove to hospital               | <input type="checkbox"/> Drove to school      |
| <input type="checkbox"/> Was driven to hospital          | <input type="checkbox"/> Was driven to school |
| <input type="checkbox"/> Taken to hospital via ambulance |   |

**In what areas did you IMMEDIATELY feel pain?**

- |   |          |                               |                                |       |                               |                                |
|---|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head                                     | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck                                     | Arm      | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back                               | Elbow    | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back                                 | Wrist    | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs                                     | Hand     | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest                                    | Fingers  | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen                                  | Buttock  | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back <input type="checkbox"/> Pelvis |          |                               |                                |       |                               |                                |

**In what areas did you experience lacerations (cuts) or contusions (bruises)?**

- |   |          |                               |                                |       |                               |                                |
|---|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head                                     | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck                                     | Arm      | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back                               | Elbow    | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back                                 | Wrist    | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs                                     | Hand     | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest                                    | Fingers  | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen                                  | Buttock  | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back <input type="checkbox"/> Pelvis |          |                               |                                |       |                               |                                |

**At the hospital, what areas were x-rayed?**

- |   |          |                               |                                |       |                               |                                |
|---|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head                                     | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck                                     | Arm      | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back                               | Elbow    | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back                                 | Wrist    | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs                                     | Hand     | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest                                    | Fingers  | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen                                  | Buttock  | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back <input type="checkbox"/> Pelvis |          |                               |                                |       |                               |                                |

**Where did you experience pain on the day FOLLOWING the accident?**

- |   |          |                               |                                |       |                               |                                |
|---|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head                                     | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck                                     | Arm      | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back                               | Elbow    | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back                                 | Wrist    | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs                                     | Hand     | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest                                    | Fingers  | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen                                  | Buttock  | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back <input type="checkbox"/> Pelvis |          |                               |                                |       |                               |                                |

**Next day discomfort...?**

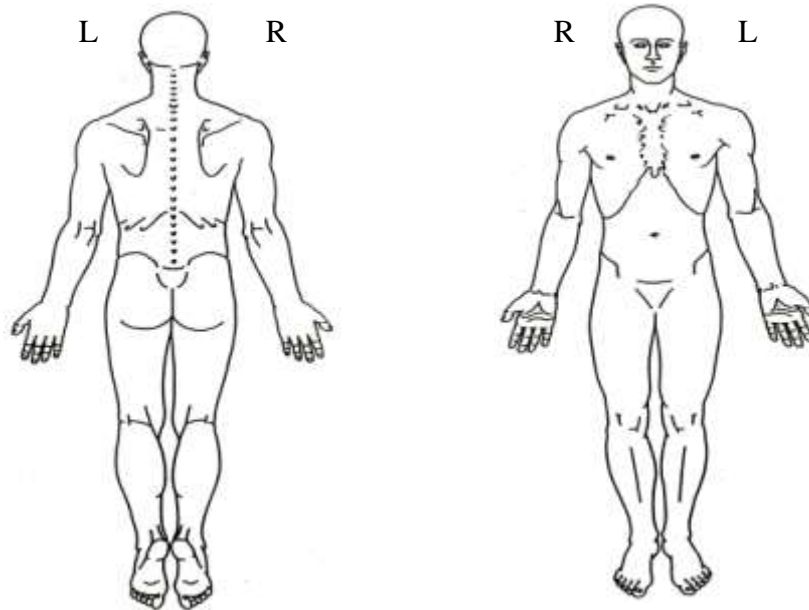
- increased  decreased  same

**Did your major complaints exist before the accident?**

- Yes  No

1. Describe your main complaint: \_\_\_\_\_

2. Mark areas of complaints on the body:



3. Rate your pain: 0=no pain 10 = extreme pain

**If Neck Pain or Headaches**

What is your neck or headache pain level at its **BEST**?

0 1 2 3 4 5 6 7 8 9 10

What is your neck or headache pain level at its **WORST**?

0 1 2 3 4 5 6 7 8 9 10

**If Low Back Pain**

What is your low back pain level at its **BEST**?

0 1 2 3 4 5 6 7 8 9 10

What is your low back pain level at its **WORST**?

0 1 2 3 4 5 6 7 8 9 10

**If Mid Back Pain**

What is your mid back pain level at its **BEST**?

0 1 2 3 4 5 6 7 8 9 10

What is your mid back pain level at its **WORST**?

0 1 2 3 4 5 6 7 8 9 10

**Other**

Pain at its **BEST**?

0 1 2 3 4 5 6 7 8 9 10

Pain at its **WORST**?

0 1 2 3 4 5 6 7 8 9 10

4. The complaints began:  immediately after accident  within days of accident  \_\_\_\_\_

5. The pain is:  constant  nearly constant  comes and goes

6. What does your main complaint feel like?

- sharp  dull  achy  throbbing  shooting  burning  pins/needles  stiff  tight  
 other \_\_\_\_\_

7. How are your symptoms changing?  getting better  getting worse  not changing

**8. What makes the PAIN worse?**

- |   |  |  |                                       |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> bending forward    | <input type="checkbox"/> lifting               | <input type="checkbox"/> lying down        | <input type="checkbox"/> looking down |
| <input type="checkbox"/> sitting            | <input type="checkbox"/> getting up & down     | <input type="checkbox"/> standing          | <input type="checkbox"/> looking up   |
| <input type="checkbox"/> driving            | <input type="checkbox"/> activities in general | <input type="checkbox"/> walking           | <input type="checkbox"/> turning head |
| <input type="checkbox"/> coughing           | <input type="checkbox"/> bending backward      | <input type="checkbox"/> cold/damp weather | <input type="checkbox"/> reaching     |
| <input type="checkbox"/> sneezing           | <input type="checkbox"/> evening               | <input type="checkbox"/> morning           |                                       |
| <input type="checkbox"/> straining at stool | <input type="checkbox"/> other _____           |  |                                       |

**9. What ACTIVITIES are you having difficulty performing (ie mowing lawn, vacuuming, doing dishes)?**

- nothing
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**10. What makes the pain better?**

- |                               |                                     |   |
|-------------------------------|-------------------------------------|---|
| <input type="checkbox"/> ice  | <input type="checkbox"/> lying down | <input type="checkbox"/> medication _____ |
| <input type="checkbox"/> heat | <input type="checkbox"/> sitting    | <input type="checkbox"/> stretching       |
| <input type="checkbox"/> rest | <input type="checkbox"/> standing   | <input type="checkbox"/> other _____      |

**11. Does the pain radiate?**

- no
- RIGHT**    upper arm    forearm    hand    buttock    thigh    calf    foot
- LEFT**    upper arm    forearm    hand    buttock    thigh    calf    foot

**12. Is there numbness/tingling?**

- no
- RIGHT**    upper arm    forearm    hand    buttock    thigh    calf    foot
- LEFT**    upper arm    forearm    hand    buttock    thigh    calf    foot

**13. Is there weakness?**

- no
- RIGHT**    upper arm    forearm    hand    buttock    thigh    calf    foot
- LEFT**    upper arm    forearm    hand    buttock    thigh    calf    foot

**14. Since the accident:**

No	Started or worse after accident	Started before accident	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anxiety?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dizziness/fainting?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	eyes sensitive to light?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fatigue?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	jaw pain or jaw clicking?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sudden severe headaches?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loss of memory?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ringing buzzing in ears?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	unexplained weight loss?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	changes in bowel or bladder function?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loss of bowel or bladder function?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nausea and/or vomiting?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	vision changes?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	pain is worse during the night?

15. Have you seen any other doctor for THIS complaint?  no one  other chiropractor  
 medical doctor  physical therapist  other \_\_\_\_\_

16. Have you been treated by another doctor for ANY condition in the last twelve months?  no  yes

Doctor's name \_\_\_\_\_ Condition? \_\_\_\_\_

17. When was your last physical exam? \_\_\_\_\_ Were there any problems?  no  yes

18. Do you have any spinal x-rays?  no  yes where were they taken? \_\_\_\_\_

19. Occupation: \_\_\_\_\_ Are you a shift worker?  no  yes

20. Have you missed work due to the accident?  no  yes=if yes,

List dates off work: \_\_\_\_\_ Have you returned to full duty work?  no  yes

21. Are you taking any prescription medications or over the counter drugs?  no  yes=if yes,

List medications: \_\_\_\_\_

## 22. Health History and Family History:

Mom	Dad	Self	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (type? osteoarthritis, rheumatoid arthritis, lupus arthritis, other)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone Fracture (which bone? _____ when? _____)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (what type? _____)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (type I or type II)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Disorders (Hiatal Hernia/Acid Reflux/Ulcers)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches (type _____ Diagnosed by MD? <input type="checkbox"/> no <input type="checkbox"/> yes)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/osteopenia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Neuropathy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea (Do you use a CPAP? <input type="checkbox"/> no <input type="checkbox"/> yes )
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
			List any other condition(s) _____

23. **List any surgeries with dates:** \_\_\_\_\_  
 \_\_\_\_\_
24. **Describe past injuries or falls?** \_\_\_\_\_  
 \_\_\_\_\_
25. **Have you been in any OTHER auto accidents?**  no  yes=when? \_\_\_\_\_ Were you treated?  no  
 yes= by whom? \_\_\_\_\_ Did you completely recover?  yes  no \_\_\_\_\_
26. **Have you had PRIOR similar complaints?**  no  yes, describe \_\_\_\_\_  
 \_\_\_\_\_
27. **Is your overall health right now:**  Excellent  Very Good  Good  Fair  Poor
28. **Do you eat mostly healthy, nutritious food?**  no  yes  not sure  
**Do you eat breakfast?**  no  yes  
**Do you want to discuss healthy eating and/or weight loss coaching with the doctor?**  no  yes  
**Do you take vitamins?**  no  yes=what? \_\_\_\_\_  
 Has your medical doctor advised you NOT to take certain vitamins?  no  yes  
 Do you have a sensitivity to shell fish?  no  yes **Warning! Glucosamine is made from shell fish!**
29. **Do you smoke or chew tobacco?**  no  yes=Packs/cans a day? \_\_\_\_\_
30. **Do you exercise?**  rarely  occasionally  regularly=what type? \_\_\_\_\_
31. **Do you have a good supportive mattress?**  no  yes  
 What is your favorite sleep position?  side  back  stomach
32. **Have you ever been treated by a chiropractor?**  no  yes If yes, What area was treated?  
 Low back, mid back, neck. Did the adjustments relieve your symptoms?  no  yes  partially
34. **Marital status:**  married-How many dependent children? \_\_\_\_\_  
 single  divorced  separated  widowed
35. **Educational level:**  high school graduate  vocational school  1 to 4 years of college
36. **(Women only) Are you pregnant?**  no  YES How many pregnancies have there been? \_\_\_\_\_  
 When was your last pap smear? \_\_\_\_\_ Was it normal?  no  yes  
 When was your last mammogram? \_\_\_\_\_ Was it normal?  no  yes
37. **(Men only) Have you had a prostate exam?**  no  yes=when?  
 Were the findings normal?  no  yes
38. **Have you hired an attorney?**  no  yes \_\_\_\_\_

Signature \_\_\_\_\_  Doctor reviewed history with patient

Patient's Name: \_\_\_\_\_

**Do you drink alcohol?**  never  yes=How many drinks a week? \_\_\_\_\_

Do you have or have you ever had a dependence on alcohol?  no  yes

If yes, are you in recovery?  no  yes

**Do you take illegal drugs?**  no  yes

Do you have or have you ever had a dependence on illegal drugs?  no  yes

If yes, are you in recovery?  no  yes

**Do you have or have you ever had a dependence on prescription drugs?**  no  yes

If yes, are you in recovery?  no  yes

**Do you suffer from any mental disorders?**  no  yes

Are you taking prescription or over the counter medication for your condition?  no  yes

If yes \_\_\_\_\_

**Do you suffer from depression?**  no  yes

Are you taking prescription or over the counter medication for depression?  no  yes

If yes \_\_\_\_\_

**Are you receiving counseling for any mental condition?**  no  yes

**Do you have AIDs or HIV?**  no  yes

**Do you suffer with Post Traumatic Stress Syndrome?**  no  yes

What is the cause? \_\_\_\_\_

**Do you have a communicable disease (such as hepatitis or tuberculosis)?**  no  yes

If yes \_\_\_\_\_

Other condition: \_\_\_\_\_

**You have the right to restrict the use and disclosure of protected health information particularly the information listed above.**

**Signed:** \_\_\_\_\_

Check if you don't want information released.

# Neck Pain Disability Questionnaire

After Vernon & Mior, 1991, rev. 1/1/95

Name \_\_\_\_\_ Date \_\_\_\_\_

**Please mark the ONE choice from EACH group that best describes you.**

## PAIN INTENSITY

- A. I have no pain at the moment.
- B. The pain is very mild at the moment.
- C. The pain is moderate at the moment.
- D. The pain is fairly severe at the moment.
- E. The pain is very severe at the moment.
- F. The pain is worst imaginable at the moment.

## PERSONAL CARE

- A. I can look after myself normally without causing extra pain.
- B. I can look after myself normally, but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help, but manage most of my personal care.
- E. I need help every day in most aspects of self care.
- F. I do not get dressed, I wash with difficulty and stay in bed.

## LIFTING

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table..
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can only lift very light weights.
- F. I cannot lift or carry anything at all.

## READING

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want to with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

## HEADACHES

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come infrequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

**CONCENTRATION**

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty concentrating when I want to.
- F. I cannot concentrate at all.

**WORK**

- A. I can do as much work as I want to
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

**DRIVING**

- A. I can drive my car without any neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive at all because of severe pain in my neck.
- F. I cannot drive my car at all.

**SLEEPING**

- A. I have no trouble sleeping.
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is midly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

**RECREATION**

- A. I am able to engage in all of my recreational activities, with no neck pain at all.
- B. I am able to engage in all of my recreational activities, with some neck pain at all.
- C. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities at all.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# Revised Oswestry Low Back Pain Disability Questionnaire

From N. Hudson, K. Tome-Nicholson, A. Breen; 1989 rev. 09/11/92

Name \_\_\_\_\_ Date \_\_\_\_\_

Please mark the ONE choice from EACH group that best describes you.

## PAIN INTENSITY

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain comes and goes and is severe.
- F. The pain is severe and does not vary much.

## PERSONAL CARE

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do some washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

## LIFTING

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weights, at the most.

## WALKING

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than one mile.
- C. Pain prevents me from walking more than ½ mile.
- D. Pain prevents me from walking more than ¼ mile.
- E. I can only walk while using a cane or on crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

## SITTING

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than ½ hour.
- E. Pain prevents me from sitting more than ten minutes.
- F. Pain prevents me from sitting at all.

**STANDING**

- A. I can stand as long as I want without pain.
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for longer than ½ hour without increasing pain.
- E. I cannot stand for longer than ten minutes without increasing pain.
- F. I avoid standing, because it increases the pain straight away.

**SLEEPING**

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping well.
- C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D. Because of pain, my normal night's sleep is reduced by less than one-half.
- E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F. Pain prevents me from sleeping at all.

**SOCIAL LIFE**

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. I have hardly any social life because of the pain.

**TRAVELING**

- A. I get no pain while traveling.
- B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain prevents all forms of travel except that done lying down.

**CHANGING DEGREE OF PAIN**

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_