FLOCK CHIROPRACTIC

MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

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Name **Date**

Date and time of injury: _____ City and Street where injury occurred:

Estimated damage to vehicle: _____ _____

Do you have auto insurance coverage? ◯ Yes ◯ No
Insurance Company: _____

Have you reported this injury to your insurance company? ◯ Yes ◯ No

Please notify our office if you retain an attorney.

Claim Number: _____

Adjustor's Name: _____

Did the police come to the accident scene and make a report? ◯ Yes ◯ No

Your vehicle's make, model and year: _____ Estimated speed at impact: _____ mph

The other vehicle's make, model and year: _____ Estimated speed at impact: _____ mph

Describe the collision in your own words: _____

_____

_____

_____

_____

Collision Description (check all that apply to you)

◯ Driver ◯ Front passenger ◯ Rear passenger ◯ Pedestrian

◯ Rear-end impact ◯ Head-on impact ◯ Right side impact ◯ Left side impact

◯ Roll-over ◯ Hit guardrail/tree ◯ Ran off road ◯ Hit and run

At the time of impact, your vehicle was:

◯ Slowing down ◯ At a complete stop

◯ Gaining speed ◯ Moving at a steady speed

At the time of impact, the other vehicle was:

◯ Slowing down ◯ At a complete stop

◯ Gaining speed ◯ Moving at a steady speed

During and after impact, your vehicle…

◯ Kept going straight, not hitting anything ◯ Kept going straight, hitting the car in front ◯ Was hit by another vehicle

◯ Spun around, not hitting anything ◯ Spun around, hitting another car ◯ Spun around, hitting an object other than a car

Describe yourself during the collision (check only those that apply to you)

◯ You were unaware of the impending collision

◯ You were aware of the impending collision and braced yourself

◯ Your body, torso and head were facing straight ahead

◯ You had your head and/or torso turned at the time of impact (circle: to the left or right)

◯ You were wearing a seat belt (with shoulder harness? Y N)

◯ You were holding onto the steering wheel at the time of impact

◯ You lost consciousness. For how long? _____

_____
Signature

Did anything hit your body from inside or outside the vehicle? Or did your body hit something?

_____

_____

When did you first notice any pain after the injury? ◯ Immediately ◯ ____ hrs later ◯ ____ days later

Type of head restraint: ◯ movable ◯ fixed ◯ no head restraint

Position of head restraint: ◯ At the top of the back of your head ◯ Midway at the back of your head ◯ At the lower part of the back of your head ◯ At the level of your neck

Emergency Treatment

Did you go to the emergency room after the collision? ◯ Yes ◯ No
If yes, name of ER: _____

Did you go to the emergency room by ambulance? ◯ Yes ◯ No

Did you or another person drive you to the emergency room? ◯ Yes ◯ No

Were you hospitalized overnight? ◯ Yes ◯ No

Did the ER doctor take x-rays? ◯ Yes ◯ No

If yes: ◯ skull ◯ neck ◯ chest ◯ low back ◯ arm/leg

Did the ER doctor give you pain medication and/or muscle relaxants? ◯ Yes ◯ No

Did you have any cuts, lacerations or bruises? ◯ Yes ◯ No

Were you given a neck collar or brace to wear? ◯ Yes ◯ No

Check the symptoms you have noticed since the collision:

◯ Headache	◯ Irritability	◯ Tension	◯ Cold hands/feet
◯ Neck pain	◯ Chest pain	◯ Shortness of breath	◯ Bussing in ears
◯ Neck stiffness	◯ Dizziness	◯ Fatigue	◯ Loss of balance
◯ Sleeping problems	◯ Head seems too heavy	◯ Depression	◯ Upset stomach
◯ Back pain	◯ Tingling in arms/legs	◯ Eyes sensitive to light	◯ Bowel changes
◯ Nervousness	◯ Numbness in arms/legs	◯ Memory loss	◯ Loss of smell/taste

Are you having difficulty completing your normal activities as a result of the accident? ◯ Yes ◯ No

If yes, describe in detail: _____

_____

If you did not see a doctor within the first week after the collision, indicate why: _____

_____

Describe any physical complaints you had before the collision: _____

_____

Have you ever been in a collision before? ◯ Yes ◯ No
If yes, describe (including date, type of collision, injuries and treatment): _____

_____

_____

Have you been able to work since the injury? ◯ Yes ◯ No

If no, you were off work: ◯ partially ◯ completely Dates: _____ to _____

_____ _____ _____
Patient's Name Signature Date

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Primary Complaint

The primary symptom that prompted me to seek care today is:

_____
_____
_____

Secondary Complaint

The secondary symptom that prompted me to seek care today is:

_____
_____
_____

Intensity How extreme are your symptoms?

0 1 2 3 4 5 6 7 8 9 10
Mild Mod Severe

Intensity How extreme are your symptoms?

0 1 2 3 4 5 6 7 8 9 10
Mild Mod Severe

Duration How often do you experience this?

◯ Constant ◯ Frequent ◯ Occasional ◯ Intermittent

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◯ Constant ◯ Frequent ◯ Occasional ◯ Intermittent

Quality of Symptoms

◯ Numbness ◯ Tingling ◯ Stiffness ◯ Dull ache
◯ Cramping ◯ Nagging ◯ Sharp ◯ Throbbing
◯ Stabbing ◯ Burning ◯ Shooting ◯ Other

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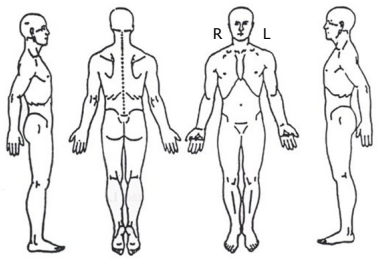
Location

Where does it hurt? Circle the area(s) on the illustration. "O" for current condition, "X" for conditions experienced in the past.



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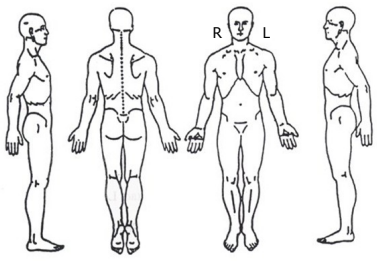

Radiation Where does your pain radiate or shoot to?

_____

Radiation Where does your pain radiate or shoot to?

_____

Aggravating or Relieving Factors

Makes it worse: _____

Makes it better: _____

Aggravating or Relieving Factors

Makes it worse: _____

Makes it better: _____

Prior Interventions What have you done for relief?

◯ Ice ◯ Heat
◯ Homeopathic Remedies ◯ Over-the-counter drugs
◯ Prescription medication ◯ Acupuncture
◯ Massage ◯ Chiropractic
◯ Physical therapy ◯ Surgery
◯ Other _____

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◯ Physical therapy ◯ Surgery
◯ Other _____

Neck Disability Index Questionnaire

This questionnaire is designed to help us better understand how your neck pain affects your ability to life activities.
Please mark the one that most closely describes your situation **right now**.

Name: _____ Date: _____

Pain Intensity

- ◯ I have no pain at the moment.
- ◯ The pain is very mild at the moment.
- ◯ The pain is moderate at the moment.
- ◯ The pain is fairly severe at the moment.
- ◯ The pain is very severe at the moment.
- ◯ The pain is the worst imaginable at the moment.

Reading

- ◯ I can read as much as I want with no neck pain.
- ◯ I can read as much as I want with slight neck pain.
- ◯ I can read as much as I want with moderate neck pain.
- ◯ I can't read as much as I want because of moderate neck pain.
- ◯ I can't read as much as I want because of severe neck pain.
- ◯ I can't read at all because of the pain.

Concentration

- ◯ I can concentrate fully without difficulty.
- ◯ I can concentrate fully with slight difficulty.
- ◯ I have a fair degree of difficulty concentrating.
- ◯ I have a lot of difficulty concentrating.
- ◯ I have a great deal of difficulty concentrating.
- ◯ I can't concentrate at all.

Work

- ◯ I can do as much work as I want.
- ◯ I can only do my usual work, but no more.
- ◯ I can do most of my usual work, but no more.
- ◯ I can't do my usual work.
- ◯ I can hardly do any work at all.
- ◯ I can't do any work at all.

Personal Care

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

Sleeping

- ◯ I have no trouble sleeping.
- ◯ My sleep is slightly disturbed for less than 1 hour.
- ◯ My sleep is mildly disturbed for up to 1-2 hours.
- ◯ My sleep is moderately disturbed for up to 2-3 hours.
- ◯ My sleep is greatly disturbed for up to 3-5 hours.
- ◯ My sleep is completely disturbed for up to 5-7 hours.

Lifting

- ◯ I can lift heavy objects without causing extra pain.
- ◯ can lift heavy weights, but it gives me extra pain.
- ◯ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned (e.g. on a table).
- ◯ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ◯ I can lift only very light weights.
- ◯ I cannot lift or carry anything at all.

Recreation

- ◯ I have no neck pain during all recreational activities.
- ◯ I have some neck pain with all recreational activities.
- ◯ I have some neck pain with a few recreational activities.
- ◯ I have neck pain with most recreational activities.
- ◯ I can hardly do recreational activities due to neck pain.
- ◯ I can't do any recreational activities due to neck pain.

Driving

- ◯ I can drive my car without neck pain.
- ◯ I can drive as long as I want with slight neck pain.
- ◯ I can drive as long as I want with moderate neck pain.
- ◯ I can't drive as long as I want because of moderate neck pain.
- ◯ I can hardly drive at all because of severe neck pain.
- ◯ I can't drive my car at all because of neck pain.

Headaches

- ◯ I have no headaches at all.
- ◯ I have slight headaches that come infrequently.
- ◯ I have moderate headaches that come infrequently.
- ◯ I have moderate headaches that come frequently.
- ◯ I have severe headaches that come frequently.
- ◯ I have headaches almost all the time.

_____
Signature

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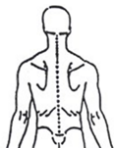
Back Pain Index Questionnaire



This form is designed to help us better understand how your back pain affects your ability to manage everyday life activities. Please mark the one that most closely describes your situation **today**.

Name: _____ Date: _____

Pain Intensity

- ◯ The pain comes and goes and is very mild.
- ◯ The pain is mild and does not vary much.
- ◯ The pain comes and goes and is moderate.
- ◯ The pain is moderate and does not vary much.
- ◯ The pain comes and goes and is severe.
- ◯ The pain is severe and does not vary much.

Sitting

- ◯ I can sit in any chair as long as I like.
- ◯ I can only sit in my favorite chair as long as I like.
- ◯ Pain prevents me from sitting more than 1 hour.
- ◯ Pain prevents me from sitting more than 30 min.
- ◯ Pain prevents me from sitting more than 10 min.
- ◯ I avoid sitting because it increases pain immediately.

Standing

- ◯ I can stand as long as I want without pain.
- ◯ I have some pain while standing but it does not increase with time.
- ◯ I cannot stand longer than 1 hour without increasing pain.
- ◯ I cannot stand longer than 30 min without increasing pain.
- ◯ I cannot stand longer than 10 min without increasing pain.
- ◯ I avoid standing because it increases pain immediately.

Walking

- ◯ I have no pain while walking.
- ◯ I have some pain while walking but it doesn't increase with distance.
- ◯ I cannot walk more than 1 mile without increasing pain.
- ◯ I cannot walk more than 1/2 mile without increasing pain.
- ◯ I cannot walk more than 1/4 mile without increasing pain.
- ◯ I cannot walk at all without increasing pain.

Personal Care

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

Changing Degree of Pain

- ◯ My pain is rapidly getting better.
- ◯ My pain fluctuates but is definitely getting better overall.
- ◯ My pain seems to be getting better but improvement is slow.
- ◯ My pain is getting neither better nor worse.
- ◯ My pain is gradually worsening.
- ◯ My pain is rapidly worsening.

Sleeping

- ◯ I get no pain in bed.
- ◯ I get pain in bed but it does not prevent me from sleeping well.
- ◯ Because of pain my normal sleep is reduced by less than 25%.
- ◯ Because of pain my normal sleep is reduced by less than 50%.
- ◯ Because of pain my normal sleep is reduced by less than 75%.
- ◯ Pain prevents me from sleeping at all.

Lifting

- ◯ I can lift heavy objects without extra pain.
- ◯ I can lift heavy objects but it causes extra pain.
- ◯ Pain prevents me from lifting heavy objects off the floor.
- ◯ Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- ◯ Pain prevents me from lifting heavy objects off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ◯ I can only lift very light weights.

Social Life

- ◯ My social life is normal and gives me no extra pain.
- ◯ My social life is normal but increases the degree of pain.
- ◯ Pain has restricted my social life and I do not go out very often.
- ◯ Pain has restricted my social life to my home.
- ◯ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing, etc).
- ◯ I have hardly any social life because of the pain.

Traveling

- ◯ I get no pain while traveling.
- ◯ I get some pain while traveling but none of my usual forms of travel make it worse.
- ◯ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ◯ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ◯ Pain restricts all forms of travel except that done while lying down.
- ◯ Pain restricts all forms of travel.

_____
Signature

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