

Accident History

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What state did the accident occur in? _____
6. What city did the accident occur in? _____
7. What street or intersection you were on when the accident occurred? _____
8. What direction were you traveling in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the accident? if yes, please describe

11. Where were you sitting in the vehicle during the accident?

12. Did you know the accident was coming? _____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact, how fast was your vehicle moving? _____
16. At the time of impact, how fast was the other vehicle moving? _____
17. During and after the crash what happened to your vehicle? (check all that apply)

<input type="checkbox"/> kept going straight	<input type="checkbox"/> spun around
<input type="checkbox"/> kept going straight hitting a car in front	<input type="checkbox"/> spun around and hit a stationary object
<input type="checkbox"/> was hit by another vehicle	<input type="checkbox"/> hit a stationary object
18. Did you lose consciousness during the accident? yes no
19. How was your head positioned during the accident? _____
20. How was your torso positioned during the accident? _____
21. How were your hands positioned during the accident? _____
22. Did your head hit anything during the accident? no yes, please describe _____
23. Did your face hit anything during the accident? no yes, please describe _____
24. Did your shoulders hit anything during the accident? no yes, please describe _____
25. Did your neck hit anything during the accident? no yes, please describe _____
26. Did your chest hit anything during the accident? no yes, please describe _____

Patient Name: _____

Accident History

27. Did your hips hit anything during the accident? no yes, please describe _____

28. Did your knees hit anything during the accident? no yes, please describe _____

29. Did your feet hit anything during the accident? no yes, please describe _____

30. What kind of headrest was in your vehicle?

- movable fixed headrest
- non-movable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? yes no

33. Did you slide out of your seatbelt during the accident? yes no

34. What was damaged in your vehicle? (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> windshield | <input type="checkbox"/> rear bumper | <input type="checkbox"/> mirror |
| <input type="checkbox"/> steering wheel | <input type="checkbox"/> front bumper | <input type="checkbox"/> knee bolster |
| <input type="checkbox"/> dashboard | <input type="checkbox"/> trunk | <input type="checkbox"/> back right door |
| <input type="checkbox"/> seat frame | <input type="checkbox"/> front left door | <input type="checkbox"/> completely totaled |
| <input type="checkbox"/> side window | <input type="checkbox"/> front right door | |
| <input type="checkbox"/> rear window | <input type="checkbox"/> back left door | |

35. Choose the items that dented inward:

- floorboards
- side door
- dashboard

36. Choose the doors that would not open as a result of the accident

- front left
- front right
- rear left
- rear right

37. Did you go to the hospital? yes no -- If no, why not (do not answer 38-43)

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized overnight? _____

41. Circle what you were prescribed at the hospital

- pain medication
- muscle relaxers
- neck brace

42. Did you receive any stitches for any cuts at the hospital? _____

43. Were x rays taken at the hospital? If yes, which area was taken?

Patient Name: _____

Legal Representation

If the patient has a representing attorney, indicate his/her name, address and phone number:

Name: _____
Street Address: _____
City: _____ State: _____
Phone number including area code: _____

Insurance information, if available:

Company: _____
Policy number: _____
Claim number: _____
Adjuster: _____
Address: _____
Phone number including area code: _____

If the patient consulted this office first, skip to past history.

Who was the first physician you consulted after the accident? Dr. _____
____ Family Physician (M.D.) _____ Chiropractor
____ Orthopedist _____ Neurologist
____ Osteopath _____ Family walk-in clinic
____ Other _____

If physiotherapy was rendered, was the patient sent out? ____ Yes ____ No

If yes, where did the patient receive the treatment?

____ Hospital
____ Other _____

Did the doctor refer the patient to or has the patient been to any other physician?

____ Yes
____ No

If yes, explain:

How long was the patient under the care of his/her physician? _____

Is the patient still under his/her care? ____ Yes ____ No

Indicate the frequency of the visits: _____

If the patient was sent for an independent medical examination, indicate the physician:

Other important information:

Patient Name _____

Past History

Does the patient have any congenital (from birth) defects which relate to this problem?

_____ Yes

_____ No

If yes, please explain:

Has the patient been involved in any previous accident(s) of any kind (auto, workers comp., slip and fall, etc.)?

_____ Yes

_____ No

If yes, please explain:

If the patient has been treated by any other physician for neck or back problems, please explain:

If the patient has undergone any surgery or experienced any conditions that are pertinent to this condition, please explain:

Did the patient enjoy good health prior to this accident? _____ Yes _____ No

Patient Name _____

Capabilities of Daily Living Assessment

Patient Name: _____

Date: _____

Directions: Please check the statements that best pertain to you in each of the following categories.

Self-Care and Personal Hygiene Care: (Washing, dressing, eating, urination, defecation, brushing teeth, brushing hair, etc.)

<input type="checkbox"/> I can provide for myself on most of my personal care <input type="checkbox"/> I can provide for myself, but it creates extra pain <input type="checkbox"/> I can provide for myself, but I am slow, careful and painful. <input type="checkbox"/> I can manage most of my personal care, but it requires some help.	<input type="checkbox"/> In most accommodations of my daily self-care, I require extra help. <input type="checkbox"/> I have difficulty bathing, stay in bed and do not dress myself. Comments: _____ _____
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Communication: (writing, speaking, seeing, bearing weight, typing, etc)

<input type="checkbox"/> I can communicate in a normal fashion. <input type="checkbox"/> I can communicate, but causes some pain. <input type="checkbox"/> My communication skills are normal, but always painful. <input type="checkbox"/> My communication skills are restricted by pain	<input type="checkbox"/> Pain seriously limits my communication except for emergencies. <input type="checkbox"/> Pain totally prevents communication. Comments: _____ _____
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Normal Living Postures: (sitting)

<input type="checkbox"/> I am able to assume a normal sitting position. <input type="checkbox"/> I can sit down for an indefinite period of time, but it causes pain. <input type="checkbox"/> I am restricted to one hour of sitting due to pain. <input type="checkbox"/> Due to pain, I am restricted to only 30 minutes of sitting.	<input type="checkbox"/> Pain restricts sitting for longer than 10 minutes. <input type="checkbox"/> I am unable to sit down due to pain. Comments: _____ _____
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Normal Living Postures: (standing)

<input type="checkbox"/> I am able to stand without restrictions. <input type="checkbox"/> I can stand for an indefinite period of time, but it causes pain. <input type="checkbox"/> I am restricted to one hour of standing due to pain. <input type="checkbox"/> Due to pain, I am restricted to only 30 minutes of standing.	<input type="checkbox"/> Pain restricts standing for longer than 10 minutes. <input type="checkbox"/> I am unable to stand due to pain. Comments: _____ _____
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Capabilities of Daily Living Assessment

Patient Name: _____

Date: _____

Normal Living Postures: (lifting)

<input type="checkbox"/> I am able to lift heavy weights without restriction.	<input type="checkbox"/> I am unable to lift or carry weights
<input type="checkbox"/> I am able to lift heavy weights, but it causes pain.	<input type="checkbox"/> Due to pain, I am not lifting heavy weights. However, light / medium weights at table height are manageable.
<input type="checkbox"/> I am unable to lift heavy weights off the floor, however I can manage if they are at table height.	<input type="checkbox"/> Pain restricts lifting to only very light weights.
<input type="checkbox"/> I am not lifting weights at all.	Comments: _____

Ambulation: (walking)

<input type="checkbox"/> I am able to walk any distance without pain restriction.	<input type="checkbox"/> I require the use of crutches or a cane to assist me with walking.
<input type="checkbox"/> I am limited to walking 1 mile due to pain restrictions.	<input type="checkbox"/> I remain in bed for the most part due to pain.
<input type="checkbox"/> I am limited to walking ½ mile due to pain.	Comments: _____
<input type="checkbox"/> Due to pain, I am restricted to walks of less than ¼ mile.	_____

Sleep: (restful, nocturnal sleep patterns)

<input type="checkbox"/> I am able to sleep in a normal fashion.	<input type="checkbox"/> I fail to accomplish 2 hours of sleep.
<input type="checkbox"/> I am able to sleep well at night, as long as I use sleeping pills.	<input type="checkbox"/> Pain prevents sleep.
<input type="checkbox"/> I fail to accomplish 6 hours of sleep.	Comments: _____
<input type="checkbox"/> I fail to accomplish 4 hours of sleep.	_____

Traveling: (driving, flying, riding, etc.)

<input type="checkbox"/> I am able to travel without restriction.	<input type="checkbox"/> Only short, urgent trips are possible due to pain.
<input type="checkbox"/> I am able to travel almost anywhere, but it causes pain.	<input type="checkbox"/> I am restricted in travel due to pain, other than emergencies of short distances (hospitals, doctors).
<input type="checkbox"/> I can manage 2 hours of travel, but pain is present and bad.	Comments: _____
<input type="checkbox"/> Due to pain, I am limited to travel time of less than one hour.	_____

Capabilities of Daily Living Assessment

Patient Name: _____

Date: _____

Non-Specialized Hand Activities: (grasping, lifting, tactile discrimination)

<input type="checkbox"/> I am able to grasp in a normal fashion.	<input type="checkbox"/> My grip and lift capabilities are normal, but always painful.
<input type="checkbox"/> I can utilize grip and tactile discrimination, but there is some pain.	<input type="checkbox"/> Pain seriously limits my grip and lifting to near absence
<input type="checkbox"/> Grip Strength, lifting, and tactile sensations are restricted by pain.	<input type="checkbox"/> Pain prevents grasping, lifting, and tactile discrimination.
	Comments: _____ _____

Sexual Function: (normal sexual function and usual participation in sexual activities)

<input type="checkbox"/> I am able to engage in normal sexual activities without pain.	<input type="checkbox"/> Pain has created a near absent sex life.
<input type="checkbox"/> I am able to participate sexually, but it creates pain.	<input type="checkbox"/> Due to pain, I abstain myself from any sexual activities.
<input type="checkbox"/> I engage normally in sexual activities, but they are very painful.	Comments: _____ _____
<input type="checkbox"/> I am restricted in sexual activities due to pain.	

Social and Recreational Activities: (Ability to participate in group activities)

<input type="checkbox"/> I am able to enjoy a normal, active social life without restrictions.	<input type="checkbox"/> I have restrictions on my social activities, therefore I do not go as often due to the presence of pain.
<input type="checkbox"/> I am able to participate in a normal social life, but pain is increased during an activity.	<input type="checkbox"/> I am restricted to social activities at home due to pain.
<input type="checkbox"/> The presence of pain affects only the more energetic aspects of my social life (sports, etc).	<input type="checkbox"/> Due to pain, I have no social life.
	Comments: _____ _____

Capabilities of Daily Living Assessment

Patient Name: _____

Date: _____

The Effects of Medication: (Painkillers, muscle relaxants, tranquilizers, psychotropics)

<input type="checkbox"/> I am able to tolerate the pain, therefore I do not use painkillers.	<input type="checkbox"/> I use painkillers and experience moderate relief from pain.
<input type="checkbox"/> Even though the pain is present, I manage to tolerate the pain without the use of painkillers.	<input type="checkbox"/> Painkillers offer very little relief from pain.
<input type="checkbox"/> I use painkillers and experience complete relief of pain.	<input type="checkbox"/> Painkillers fail to offer relief, therefore I no longer use them.
Comments: _____	

Pain Intensity: (Ability to participate in group activities)

<input type="checkbox"/> My pain is MINIMAL and tolerated, it is annoying, but does not limit my physical performance.	<input type="checkbox"/> I experience MODERATE pain which causes a marked limitation on the performance of activities of daily living.
<input type="checkbox"/> My pain is SLIGHT and tolerated, but it causes some limitations on my physical performance.	<input type="checkbox"/> I experience MARKED pain which reduces the capability to perform activities of daily living.
Comments: _____	

Pain Frequency:

<input type="checkbox"/> I have INTERMITTENT symptoms occurring less than 25% of awoken time.	<input type="checkbox"/> Pain is FREQUENT and occurs between 50 and 75% of awoken time.
<input type="checkbox"/> I have OCCASIONAL symptoms between 25% and 50% of awoken time.	<input type="checkbox"/> I have CONSTANT pain occurring between 75% and 100% of awoken time.
Comments: _____	