AUTOMOBILE ACCIDENT QUESTIONNAIRE

Dear Patient: This information is considered confidential. We need this information because your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as accurate as possible while completing this form. Thank you.

Name: _____ **Date of Birth:** _____
(First, Middle Initial, & Last)

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Home Phone:** _____ **Business Phone:** _____

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed **Sex:** □ M □ F

Spouse's Information (if applicable):
Name: _____ Employer: _____ Location: _____

Employment Information:
Occupation: _____ Business Phone: _____
(Indicate if child, student, housewife, unemployed, retired)
Employer/Company Name: _____ Location: _____

Accident/Insurance Information:
Please explain in detail how your accident happened:

_____
_____
_____

Insurance Co: _____ Policy No: _____ Claim No: _____
Driver of other vehicle (if any):
Name: _____ Insurance Co: _____ Policy No: _____
Driver of vehicle in which you were injured (if applicable):
Name: _____ Insurance Co: _____ Policy No: _____
Name of your Insurance Adjuster: _____
Have you retained an attorney? □ Yes □ No If so, her/his name & address:
_____
You were heading □ North □ East □ South □ West on _____ (street or highway)
Other vehicle (if applicable) was headed □ North □ East □ South □ West on _____ (street or highway)
Were police notified: □ Yes □ No
Were you knocked unconscious? □ Yes □ No If so, for how long? _____
Were you struck from □ Behind □ Front □ Left Side □ Right Side
Were you □ Driver □ Passenger □ Front Seat □ Back Seat □ Using Seat Belts □ Other Protective Devices
What were the time and date of present injury? _____
Where did you feel pain *immediately* after the accident? _____
Where were you taken after the accident? _____
What treatment was given? _____
Was any other doctor consulted after your accident? □ Yes □ No
If so, what was the doctor's name: _____ □ D.C. □ M.D. □ D.O. □ D.D.S. □ Other
What was the 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 this injury are your symptoms □ Improving? □ Getting worse? □ Same?

Patient Name: _____Date: _____

HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes:
1 – never had, 2 – previously had, 3 – presently have

Musculo-Skeletal System

___ Low back problems
___ Pain between shoulders
___ Neck Problems
___ Arm Problems
___ Leg Problems
___ Swollen joints
___ Painful joints
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Ruptures
___ Broken bones

Genito-Urinary System

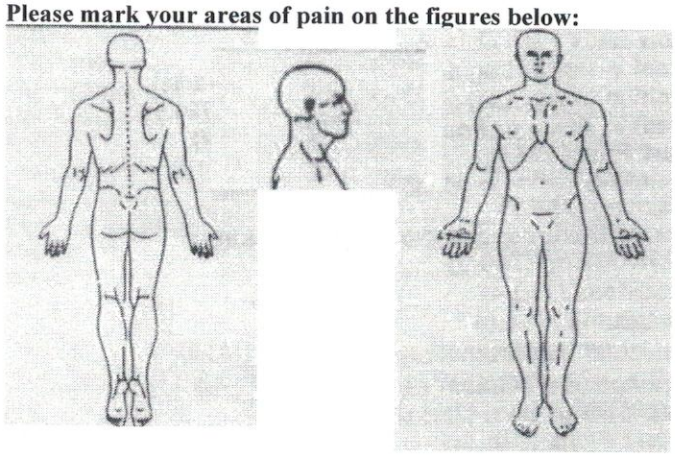
___ Bladder trouble
___ Excessive urination
___ Scanty urination
___ Painful urination
___ Discolored urine

FEMALE

___ Vaginal discharge
___ Vaginal bleeding
___ Vaginal pain
___ Breast pain
___ Lumps on breast

Are you pregnant?
___ Yes ___ No

Please mark your areas of pain on the figures below:



Gastro-Intestinal System

___ Poor appetite
___ Excessive hunger
___ Difficult chewing
___ Difficult swallowing
___ Excessive thirst
___ Nausea
___ Vomiting food
___ 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
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

Cardio-Vascular Respiratory

___ Chest pain
___ Pain over heart
___ Difficult breathing
___ Persistent cough
___ Coughing phlegm
___ Rapid heartbeat
___ Blood pressure prob.
___ Heart problems
___ Lung problems
___ Varicose Veins

EYE, EAR, NOSE, THROAT

___ Eye strain
___ Eye inflammation
___ Vision problems
___ Ear pain
___ Ear noises
___ Ear discharge
___ Hearing loss
___ Nose pain
___ Nose bleeding
___ Nose discharge
___ Diff. breath. thru nose
___ Sore gums
___ Dental problems
___ Sore mouth
___ Sore throat
___ Hoarseness
___ Difficult speech

_____

Patient's Signature

DO NOT WRITE BELOW THIS LINE

NOTES:

Patient Name: _____ DOB: _____ Date: _____

DUTIES UNDER DURESS

Have you continued to do any of the following activities despite the pain caused by your accident?

WORK

Why have you continued to work?

☐ I would lose my job if I took time off. ☐ I couldn't support my family otherwise.
☐ I don't believe in taking time off even when I am injured or in pain.
☐ I cannot take time off, because I care for my own children.
☐ My business would fail if I did not work. ☐ Other: _____

I have experienced the following changes in my ability to perform at work:

☐ Mobility/Stability Problems ☐ Climbing ☐ Kneeling ☐ Lifting ☐ Walking for Long Periods
☐ Dexterity Problems ☐ Finger Movements ☐ Wrist Movements ☐ Problems with Fatigue
☐ Postural Difficulties ☐ Bending ☐ Sitting for Long Periods ☐ Standing for Long Periods
☐ Stooping ☐ Problems with Anxiety/Depression ☐ Problems with Vertigo or Spinning Sensations
☐ Dizziness ☐ Giddiness ☐ Sensation of Irregular Motion ☐ Sensation of Whirling Motion
☐ Problems with Tinnitus or Ringing in the Ears ☐ Problems with Reduced Concentration
☐ Can't Concentrate ☐ Can't Think Properly ☐ Making Mistakes
☐ Pain: Where?_____

Duration of Symptoms

☐ I experienced problems doing my normal work activities for _____ weeks.
☐ My doctors have instructed me that my inability to perform my normal pre-accident work activities without pain is a permanent condition.
☐ My problems in performing my normal work activities is ongoing, but my doctors have not instructed me that the conditions is permanent.

HOUSEHOLD

I have experienced problems with the following activities outside my home:
☐ Painting the Outside of the House ☐ Landscaping ☐ Mowing the Grass ☐ Trimming the Bushes/Trees ☐ Washing Windows ☐ Gardening ☐ Taking Out the Trash ☐ Washing the Cars ☐ Maintaining the Cars ☐ Maintaining Yard Equipment ☐ Doing Other External House Work; Specify:_____
_____

Duration of Symptoms

☐ I experienced problems doing my normal household activities for _____ weeks.
☐ My doctors have instructed me that my inability to perform my normal pre-accident household activities without pain is a permanent condition.
☐ My problems in performing my normal household activities is ongoing, but my doctors have not instructed me that the conditions are permanent.

Patient Name: _____ DOB: _____ Date: _____

DOMESTIC DUTIES

I have experienced pain while performing the following activities inside my home, but have done them anyway: ☐ Laundry ☐ Dishwashing ☐ Vacuuming ☐ Washing Windows ☐ Cleaning ☐ Preparing Meals

Due to my injuries, I have brought in the following assistance:

☐ Paid Housekeeper ☐ Unpaid Assistance ☐ None

My family status would best be described as: ☐ Single ☐ Single Parent at Home ☐ Spouse Only

☐ Spouse and Children at Home

I have the following number of children: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ ____

The number of my children in the following age category is:

☐ Number of children 0 to 5 years: _____ ☐ Number of children 5-11 years: _____

☐ Number of children older than 11: _____

Domestic Assistance

☐ I do receive domestic assistance ☐ I do not receive domestic assistance

Duration of Symptoms

☐ I have experienced problems doing my normal domestic activities for _____ weeks.

☐ My doctors have instructed me that my inability to perform my normal pre-accident domestic activities without pain is a permanent condition.

☐ My problems in performing my normal domestic activities is ongoing, but my doctors have not instructed me that the condition is permanent.

STUDIES/EDUCATIONAL DUTIES

As a student I have experienced problems with one of the following activities since the collision:

☐ Carrying Books ☐ Sitting in Classes ☐ Looking Down to Read Textbooks

☐ Other: _____

I have also experienced the following changes in my ability to perform at school as a result of injuries sustained in my accident:

☐ Mobility/Stability Problems ☐ Climbing ☐ Kneeling ☐ Lifting

☐ Walking for Long Periods ☐ Dexterity Problems ☐ Finger Movements ☐ Wrist Movements

☐ Problems with Fatigue ☐ Postural Difficulties ☐ Bending ☐ Sitting for Long Periods

☐ Standing for Long Periods ☐ Stooping ☐ Problems with Anxiety/Depression

☐ Problems with Vertigo or Spinning Sensations ☐ Dizziness ☐ Giddiness

☐ Sensation of Irregular Motion ☐ Sensation of Whirling Motion

☐ Problems with Tinnitus or Ringing in the Ears ☐ Problems with Reduced Concentration ☐ Can't Concentrate ☐ Can't Think Properly ☐ Making Mistakes

☐ Pain: Where? _____

At the time of this collision, my education would best be described as:

☐ High School ☐ Apprenticeship Studies ☐ Technical College ☐ University ☐ Correspondence Course My attendance before the collision is best described as: ☐ Full Time ☐ Part Time Duration of Symptoms ☐ I have experienced problems doing my normal studies/educational activities for _____ weeks.

☐ My doctors have instructed me that my inability to perform my normal pre-accident studies/educational activities without pain is a permanent condition.

☐ My problems in performing my normal studies/educational activities is ongoing, but my doctors have not instructed me that the condition is permanent.

_____ _____

Print Name (Patient) Date

_____

Patient Signature

Patient Name: _____DOB: _____ Date: _____

LOSS OF ENJOYMENT OF LIFE INDEX

This form is to determine whether you have lost the enjoyment of certain activities in your life, or lost status or skills in these activities as a result of your injuries from this accident.

Work Activities

☐ I have lost enjoyment in performing my job as a result of the injuries caused in this accident.

☐ My employment status at the time of the accident is best described as:

☐ Full Time Employed ☐ Part Time Employed ☐ Casual Employee ☐ Seasonal Employee ☐ Not Employed

If your answer is Full Time, Part Time, or Casual Employee, which of the following categories best describes your work capacity since this accident: ☐ I Resumed My Same Job and Duties ☐ I Resumed My Same Job with Lighter Duties

☐ I Resumed Alternate Duties Within the Same Industry ☐ I Changed Industry

☐ I Have Not Resumed Work

The injuries from this accident have had the following effects on my work:

☐ I have lost status within the company.

☐ I have lost job security.

☐ I have lost promotional prospects.

☐ I have difficulty in performing my normal job duties.

☐ My quality of work is reduced since the accident.

☐ I am unable to perform my pre-accident job domestic activities

☐ I have lost enjoyment in performing my domestic activities as a result of the injuries caused in this accident.

☐ I have experienced a loss of enjoyment with the following activities inside my home, since the accident:

☐ Laundry ☐ Dishwashing ☐ Vacuuming ☐ Washing Windows ☐ Cleaning ☐ Preparing Meals

☐ Other: _____

Household Activities

☐ I have lost enjoyment in performing my household activities, outside the home, as a result of the injuries caused in this accident.

☐ I have experienced problems with the following activities outside my home:

☐ Painting the Outside of the House ☐ Landscaping ☐ Mowing the Grass ☐ Trimming the Bushes/Trees ☐ Washing Windows

☐ Gardening ☐ Taking Out the Trash ☐ Washing the Cars ☐ Maintaining the Cars ☐ Maintaining Yard ☐ Equipment

☐ Doing Other External Housework; Specify: _____

Studies/Educational Activities

☐ I have lost enjoyment in performing my educational activities as a result of the injuries caused in this accident.

☐ I am no longer able to attend school. ☐ I have dropped to part time. ☐ My grades have dropped.

☐ I have been forced to change schools due to the injuries.

Before the Accident, I was attending: ☐ High School 3 ☐ College ☐ Other Hobby Activities ☐ Apprenticeship Studies

☐ Technical College ☐ University; Specify_____ ☐ Correspondence Course

☐ Graduate College/University; Specify College & Degree:_____

I am now attending: ☐ High School ☐ Apprenticeship Studies ☐ Technical College ☐ A Different University; Specify

_____

☐ I have lost enjoyment in performing hobby activities as a result of the injuries caused in this accident.

Patient Name: _____DOB: _____ Date: _____

Effect of Accident on Enjoyed Activities

Activity #1 _____

Prior to the Accident, I performed this activity at the following level: ☐ Informal/ Amateur ☐ Competitive ☐ Semi-Professional ☐ Professional

Prior to the accident: ☐ I did not make money with this hobby ☐ I make money with this hobby

After this Accident, I performed this hobby activity at the following level: ☐ I can't perform the activity at all ☐ Informal/ Amateur ☐ Competitive ☐ Semi-Professional ☐ Professional

After this accident: ☐ I do not make money with this hobby ☐ I make money with this hobby I make $_____/month on average with this hobby, as reported to the IRS.

Duration of Symptoms ☐ I did not enjoy this activity for _____ weeks. ☐ My doctors have instructed me that my inability to enjoy this activity without pain is a permanent condition. ☐ My problems in enjoying this activity is ongoing, but my doctors have not instructed me that the condition is permanent.

Activity #2 _____

Prior to the Accident, I performed this activity at the following level: ☐ Informal/ Amateur ☐ Competitive ☐ Semi-Professional ☐ Professional

Prior to the accident: ☐ I did not make money with this hobby ☐ I made money with this hobby.

After this Accident, I performed this hobby activity at the following level: ☐ I can't perform the activity at all ☐ Informal/ Amateur ☐ Competitive ☐ Semi-Professional ☐ Professional

After this accident: ☐ I do not make money with this hobby ☐ I make money with this hobby

Duration of Symptoms

☐ I did not enjoy this activity for _____ weeks. ☐ My doctors have instructed me that my inability to enjoy this activity without pain is a permanent condition. ☐ My problems in enjoying this activity is ongoing, but my doctors have not instructed me that the condition is permanent.

Sports: Activity #1 _____

Prior to the Accident, I performed this sport at the following level: ☐ Informal/Social/Amateur ☐ Competitive ☐ Regionally Recognized ☐ Semi-Professional ☐ Professional Prior to the accident: ☐ I did not make money with this sports activity ☐ I make money with this sports activity

After this Accident, I perform this activity at the following level: ☐ Informal/Social/Amateur ☐ Competitive ☐ Regionally Recognized ☐ Cannot Play the Original Sport ☐ Cannot Play Any Sports After the accident: ☐ I do not make money with this sports activity ☐ I make money with this sport

Duration of Symptoms ☐ I did not enjoy this activity for _____ weeks. ☐ My doctors have instructed me that my inability to enjoy this activity without pain is a permanent condition. ☐ My problems in enjoying this activity is ongoing, but my doctors have not instructed me that the condition is permanent.

Sports Activity #2 _____

Prior to the Accident, I performed this sport at the following level: ☐ Informal/Social/Amateur ☐ Competitive ☐ Regionally Recognized ☐ Semi-Professional ☐ Professional Prior to the accident: ☐ I did not make money with this sports activity ☐ I make money with this sports activity

After this Accident, I perform this activity at the following level: ☐ Informal/Social/Amateur ☐ Competitive ☐ Regionally Recognized ☐ Cannot Play the Original Sport ☐ Cannot Play Any Sports After the accident: ☐ I do not make money with this sports activity ☐ I make money with this sport

Duration of Symptoms ☐ I did not enjoy this activity for _____ weeks. ☐ My doctors have instructed me that my inability to enjoy this activity without pain is a permanent condition. ☐ My problems in enjoying this activity are ongoing, but my doctors have not instructed me that the condition is permanent.

Patient Name: _____DOB: _____ Date: _____

Traveling Activity #1 _____

Prior to the Accident, I performed this activity at the following level: ☐ Pleasure Travel ☐ Business Travel ☐ Yearly ☐ Seasonal

After this Accident, I altered this travel in the following way: ☐ I cancelled the travel plans ☐ I didn't make the normal travel plans ☐ I altered the travel plans due to the injury

☐ I went, but with an increased level of pain ☐ I went, but was impaired in my activities ☐ I went and had minimal trouble ☐ I went and had no trouble traveling

_____

Print Name (Patient)

_____

Patient Signature