Motor Vehicle Accident Information

Patient Name: ________________________________ Date of Accident: _____________

General Information
Patient Location:
Check all that applies:

What was your location in the vehicle?	☐ Driver	☐ Passenger	
If passenger, what location?	☐ Front	☐ Middle	☐ Rear
	☐ Left	☐ Middle	☐ Right

Vehicle Description:
Check all that applies:

Type:	☐ Car	☐ Van	☐ Truck	☐ Bus	☐ SUV	☐ Motorcycle	☐Other_____________
Size:	☐ Compact	☐ Mid Size	☐ Full Size				
Action:	☐ Stopped	☐ Slowing	☐ Acceleration	☐ Cruising			
Speed:	___________MPH						
Time of accident:	☐ Day light	☐ Dawn	☐ Dusk	☐ Dark			
Road Condition:	☐ Dry	☐ Damp	☐ Wet	☐ Snow	☐ Ice		
Visibility:	☐ Good	☐ Fair	☐ Poor				

Impact Information:
Check all that applies:

What impacted the vehicle: ☐ Vehicle ☐ Object

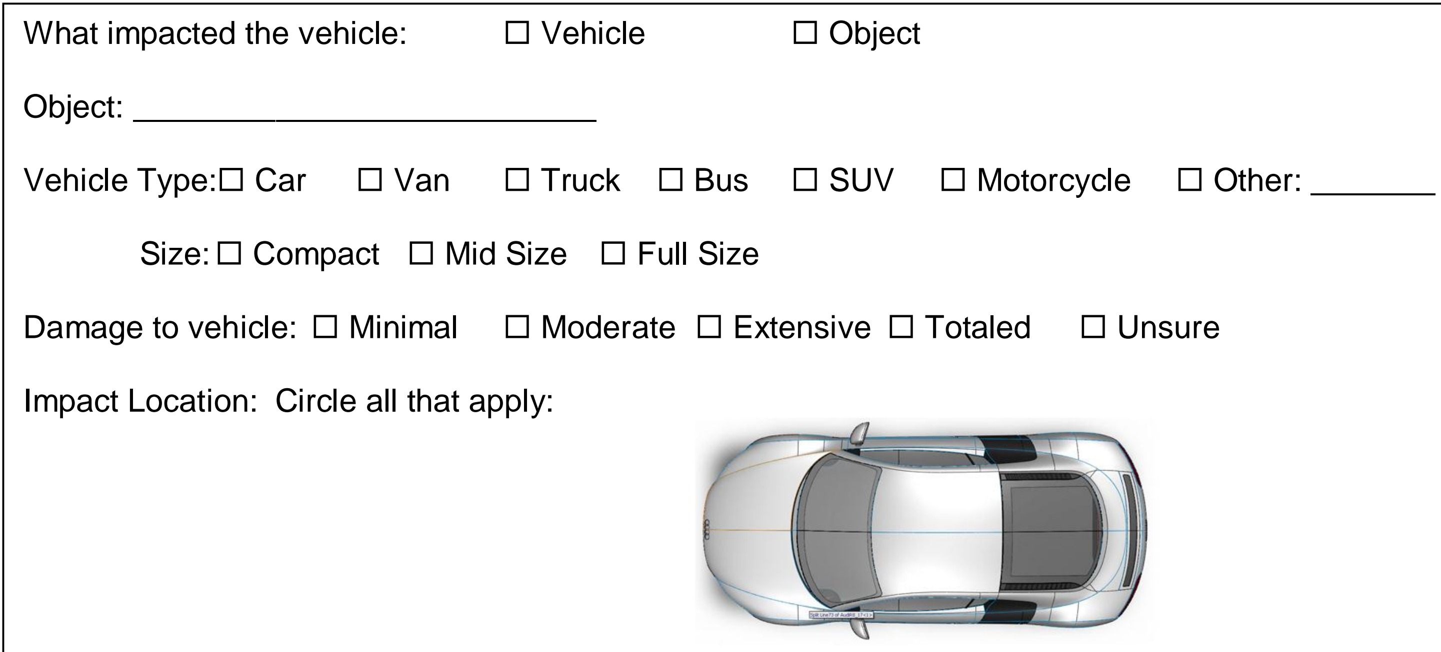
Object: ____________________________

Vehicle Type: ☐ Car ☐ Van ☐ Truck ☐ Bus ☐ SUV ☐ Motorcycle ☐ Other: _______

Size: ☐ Compact ☐ Mid Size ☐ Full Size

Damage to vehicle: ☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure

Impact Location: Circle all that apply:



During Impact Information:
Check all that applies:

Seat Belt Impact? ☐ Yes ☐ No Brakes Applied? ☐ Yes ☐ No

Air Bag Deployed? ☐ Yes ☐ No Seat Broken? ☐ Yes ☐ No

Prepare for Accident: ☐ Un-Expected ☐ Expected ☐ Expected and Braced

Head Rest Position: ☐ Low ☐ Mid ☐ High ☐ None

Body Position: ☐ Straight ☐ Rotated Left ☐ Rotated Right ☐ Unsure ☐ Other _____

Body Thrown: ☐ Yes ☐ No

Direction of Throw: ☐ Backwards ☐ Forward ☐ Outside ☐ Unsure ☐ Other ________

Head Position: ☐ Straight ☐ Rotated Left ☐ Rotated Right ☐ Forward ☐ Unsure

Head Motion: ☐ Forward Backwards ☐ Backwards Forward ☐ Right Left ☐ Left Right

☐ Unsure ☐ Other: ___________________________

Body Impact:
During the Accident:

☐ Left Hand ☐ Right Hand ☐ Upper Back ☐ Mid Back ☐ Lower Back

☐ Left Shoulder ☐ Right Shoulder ☐ Upper Torso ☐ Mid Torso ☐ Lower Torso

☐ Left Elbow ☐ Right Elbow ☐ Left Leg ☐ Right Leg ☐ Head

☐ Left Foot ☐ Right Foot ☐ Left Knee ☐ Right Knee

☐ Left Arm ☐ Right Arm ☐ Other: _________________________

Numbness: ☐ Left Hand ☐ Right Hand ☐ Left Arm ☐ Right Arm

☐ Left Leg ☐ Right Leg ☐ Left Foot ☐ Right Foot

☐ Other: __________________________

After Accident Information:
Immediately following Accident Symptoms:

☐ Dizzy/Dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented

☐ Unconscious ☐ Other: ___________________________

Patient Signature: _____________________________________ Date: ______________

Medical Information:

Did you receive medical care? ☐ Yes ☐ No

If yes, please check off the following that apply:

Time of Accident: ☐ Next Day ☐ At time of Accident ☐ Later that Day ☐ Days Later: ___

Transportation: ☐ Drove Self ☐ Ambulance ☐ Other: ________________

Went To: ☐ Chiropractor ☐ Family Dr. ☐ ER ☐ Urgent Care (Patient First)

☐ Other: ___________________

Admitted to Hospital: ☐ No ☐ Yes How many days spent in hospital: _________

Test: ☐ X-Ray ☐ Lab work ☐ MRI ☐ CT Scan ☐ Other: ____________

Treatment: ☐ Ice Pack ☐ Hot Pack ☐ Cervical Collar ☐ Medication

☐ Other: _____________________

Previous Injuries

Previous Injuries/ Accidents: ☐ No ☐ Yes Specify: _________________________

____

Residual pain from Previous Injury/ Accidents: ☐ No ☐ Yes Specify: ______________

____

Later Symptoms:

Head: ☐ Headache ☐ Dizziness ☐ Blurred Vision ☐ Light Headedness

☐ Loss of Vision ☐ Fainting ☐ Loss of Memory ☐ Pain in Ear

☐ Double Vision ☐Other: ____

Neck: ☐ Pain in Neck ☐ Tilt Forward ☐ Bend Left ☐ Turn Left

☐ Muscle Spasm ☐ Tilt Backward ☐ Bend Right ☐ Turn Right

☐ Popping in Neck ☐ Other: ____

Patient Signature: _______________________________________ Date: ______________

Shoulders: ☐ Pain in Joint ☐ Tension in Shoulder ☐ Muscle Spasms

☐ Pain Across Shoulder ☐ Cant Raise Arms Above Shoulder Level

☐ Cant Raise Arms Over Head ☐ Other: _______________

Arms and Hands: ☐ Pain in Fingers ☐ Hands Cold ☐ Loss of Grip Strength

☐ Pins and Needles in Hands ☐ Pins and Needles in Fingers

☐ Numbness in Left Arm ☐ Numbness in Right Arm

☐ Swollen Joints in Fingers ☐ Other: _______________

Chest: ☐ Chest Pain ☐ Pain Around Ribs ☐ Shortness of Breath

☐ Breast Pain ☐ Other: _______________

Abdomen: ☐ Nervous Stomach ☐ Nausea ☐ Diarrhea

☐ Gas ☐ Constipation ☐ Other: _____________

Mid Back: ☐ Sharp Stabbing ☐ Mid Back Pain ☐ Pain from Font to Back

☐ Dull Ache ☐ Pain in Kidney Area ☐Muscle Spasms

☐ Pain Between Shoulders ☐ Other: _______________

Lower Back: ☐ Low Back Pain

Lower back pain is worse when: ☐ Working ☐ Sitting ☐ Lifting ☐ Bending

☐ Coughing ☐Standing ☐ Laying Down ☐ Muscle Spasms

☐ Other: ______________

Hips, Legs, & Feet: ☐ Pain and Needles in Legs ☐ Pain in Buttocks ☐ Pain down Leg

☐ Pain in Hip Joint ☐ Feet Feel Cold ☐ Swollen Feet

☐ Numbness in Toes ☐ Numbness of Leg ☐ Cramps in feet

☐ Knee Pain ☐ Leg Cramps ☐Cramps in Feet

☐ Other: _______________

Patient Signature: _______________________________________ Date: _______________

General: ☐ Nervous ☐ Fatigue ☐ Irritable ☐ Depressed ☐ Cramping

☐ Generally Feel Run Down ☐ Prostate Pain/Swelling

☐ Difficulty Urinating ☐ Night Urination ☐ Irregularity

☐ Loss of Sleep: __________ hrs per night

☐ Loss of Weight: _________ lbs

☐ Gain of Weight: _________ lbs

Other:

Brief Description of Accident in your words:

Patient Signature: ______________________________________ Date: ______________

CAD Symptoms Questionnaire

Name: ____ Date: _________________

Please check any symptoms you now have that you consider important.

☐ Vertigo (a severe form of unsteadiness that makes you have to stop moving completely for a while)
☐ Nausea caused by extremes of motion of the neck (i.e., full head turning or bending of the neck toward the chest)
☐ Pain or stiffness from neck to shoulders region(s)
☐ Electric shock-like sensations over the back of the head with certain motions of the neck.
☐ Inability to hold neck still for more than a few moments (restless neck syndrome)
☐ Occasional fainting or near fainting.
☐ Pain in the back (but no the front) of the back; neck stiffness.
☐ Neck sometimes locks or gets stuck in forward bending position.
☐ Neck sometimes locks or gets stuck when turning head right or left.
☐ Jaw joint pain, stiffness.
☐ Loss of sense of smell.
☐ Headaches
☐ Blurred vision
☐ Blurred vision in one eye, but not the other eye.
☐ Double vision or blurred vision.
☐ Dizziness, loss of balance, or feelings of unsteadiness.
☐ Difficulty with speech.
☐ Numbness or tingling in one or both upper extremities (arm, forarm, hand, fingers)
☐ Amnesia
☐ Back sometimes locks in forward bending positions-hard to straighten out.
☐ Numbness and tingling over spine (back) in either the neck or back regions
☐ Upper back pain; stiffness.
☐ Pain in one or both upper extremities (arm, forearm, hand, fingers)
☐ Numbness or tingling in both hands and both feet, but not elsewhere.
☐ Frequently drop objects.
☐ Lower back pain; stiffness.

On a scale of 0-10 please circle what level is relevant to you as to how whiplash has affected you.

1. How much **pain** do you have today?

0 1 2 3 4 5 6 7 8 9 10
no pain ... Worst pain imaginable.

2. How often do you experience **tiredness/fatigue** as a result of your whiplash injury/symptoms?

0 1 2 3 4 5 6 7 8 9 10
Not at all ... Always

3. How often do you experience **sadness/depression** as a result of your whiplash injury/symptoms?

0 1 2 3 4 5 6 7 8 9 10
Not at all ... Always

4. How often do you experience **anger** as a result of your whiplash injury/symptoms?

0 1 2 3 4 5 6 7 8 9 10
Not at all ... Always

5. How often do you experience **anxiety** as a result of your whiplash injury/symptoms?

0 1 2 3 4 5 6 7 8 9 10
Not at all ... Always

6. How has your condition **changed** over the past month?

-5 -4 -3 -2 -1 0 1 2 3 4 5
Much worse ... No change ... Much better

Neck Disability Index

Name: ____________________________________ Date: _____________

This questionnaire has been designed to give the doctor information as to how your NECK pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

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.

Personal Care (Washing, Dressing ect.)

☐ 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.

Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights, but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned, for example, on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can only lift very light weights at the most.
☐I cannot lift or carry anything at all.

Reading

☐ I can read as much as I want to, with no pain in my neck.
☐ I can read as much as I want to, with slight pain in my neck.
☐ I can read as much as I want to, with moderate pain in my neck.
☐ I canøt read as much as I want, because of the moderate pain in my neck.
☐ I can hardly read at all, because of the severe pain in my neck.
☐ I cannot read at all.

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.

Concentration

☐ I can concentrate fully when I want to, with no difficulty.
☐ I can concentrate fully when I want to, with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Work
☐ I can do as much work as I want to.
☐ I can do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I canøt do any work at all.

Driving
☐ I can drive my car without any neck pain.
☐ I can drive my car as long as I want, with slight pain in my neck.
☐ I can drive my car as long as I want, with moderate pain in my neck.
☐ I canøt drive my car as long as I want, because of moderate pain in my neck.
☐ I can hardly drive at all, because of the severe pain in my neck.
☐ I canøt drive my car at all.

Sleeping
☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr sleepless).
☐ My sleep is mildly disturbed (1-2 hrs sleepless).
☐ My sleep is moderately disturbed (2-3 hrs sleepless).
☐ My sleep is greatly disturbed (3-5 hrs sleepless).
☐ My sleep is completely disturbed (5-7 hrs sleepless).

Recreation
☐ I am able to engage in all my recreation activities, with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some neck pain.
☐ I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
☐ I am able to engage in few of my recreation activities, because of pain in my neck.
☐ I can hardly do any recreation activities, because of pain in my neck.
☐ I canøt do any recreation activities at all.

Oswestry Disability Index (For Low Back)

Name: ____ Date: ____________

This questionnaire has been designed to give the doctor information as to how your LOWER BACK pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

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 very severe.
☐ The pain is severe and does not vary much.

Personal Care

☐ I would not have to change my way of washing or dressing in order to avoid pain.
☐ I do not normally change my way or 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 or 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.

Lifting

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

Walking

☐ I have no pain on walking.
☐ I have some pain on walking, but it does not increase with distance.
☐ I cannon walk more then one mile without increasing pain.
☐ I cannot walk more then ½ mile without increasing pain.
☐ I cannot walk more than ¼ mile without increasing pain.
☐ I cannot walk at all without increasing pain.

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 one hour.
☐ Pain prevents me from sitting more than ½ hour.
☐ Pain prevents me from sitting more then 10 minutes.
☐ I avoid sitting because it increases pain right away.

Standing

☐ I can stand as long as I want without pain.
☐ I have some pain on standing, but it does not increase with time.
☐ I cannot stand for longer than one hour without increasing pain.
☐ I cannot stand for longer than ½ hour without increasing pain.
☐ I cannot stand for longer than 10 minutes without increasing pain.
☐ I avoid standing because it increases the pain right away.

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 nightøs sleep is reduced by less than ¼.
☐ Because of pain, my normal nightøs sleep is reduced by less than ½.
☐ Because of pain, my normal nightøs sleep is reduced by less than ¾.
☐ Pain prevents me from sleeping well.

Social Life
☐ My social life is normal and gives me no pain.
☐ My social life is normal, but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, ect.
☐ Pain has restricted my social life and I do not go out very often.
☐ Pain has restricted my social life to my home.
☐ 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 my usual forms of travel makes it any worse.
☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
☐ I get extra pain while traveling, which compels me to seek alternative forms of travel.
☐ Pain restricts all forms of travel.
☐ Pain prevents all forms of travel except that done lying down.

Changing Degree of Pain
☐ My pain is rapidly getting better.
☐ My pain fluctuates, but is defiantly getting better.
☐ My pain seems to be getting better, but Improvement is slow at present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Roland-Morris (Low Back Pain)

Name: ____ Date: _______________

Please read instructions: When your back hurts, you may find it difficult to some of the things you normally do. Mark only the sentences that describe you today.

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try to get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back I lie down to rest more often.
- ☐ Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I only stand up for short periods of time because of my back.
- ☐ Because of my back, I try not to bend of kneel down.
- ☐ I find it difficult to get out of a chair because of my back.
- ☐ My back is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back.
- ☐ I have trouble putting on my sock (or stockings) because of the pain in my back.
- ☐ I can only walk short distances because of my back pain.
- ☐ I sleep less well because of my back.
- ☐ Because of my back pain, I get dressed with that help of someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.