Smith Chiropractic, PSC

Dr. Jeff Smith, D.C.
1104 N. Main St. * Monticello, KY 42633
606-340-0340

For Auto Accident Cases:

Personal injury protection, also known as pip coverage only allows a certain dollar limit to cover medical expenses.

Due to PIP coverage being limited, Smith Chiropractic will require a copy of your current medical insurance card to act as a secondary payor if the PIP coverage is exhausted when we bill for services rendered. You will be responsible for any deductibles, copays or co-insurance that your medical insurance states is due.

If you do not have any active medical insurance, you will be fully responsible for all charges on your account even if your case is in litigation. You may pay with cash or credit card only. Thank you.

_____

Patient Print Name

_____

Patient Signature

_____

Date

CONFIDENTIAL PATIENT INFORMATION

DATE ___/___/___

PLEASE PRINT

PATIENT INFORMATION:

FULL NAME_____ DATE OF BIRTH ___/___/___ AGE ___ Male ☐ Female ☐

ADDRESS_____ APT#_____ SSN ____ - ____ - ____

CITY _____ STATE ____ ZIP CODE _____ HOME PHONE (_____)_____

CELL PHONE (_____)_____ CELL CARRIER _____ EMAIL _____

EMPLOYER'S NAME _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ STATE ____ ZIP _____

WORK PH. # (_____)_____ EXT._____ DATE SYMPTOMS BEGAN: ___/___/___

MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT _____ PHONE_____

CLAIM INFORMATION:

IS YOUR CONDITION DUE TO AN AUTO ACCIDENT ☐ A PERSONAL INJURY ☐ A WORK INJURY ☐ OTHER ☐

TYPE OF CLAIM: CASH ☐ GROUP HEALTH INS ☐ PERSONAL INJURY ☐ WORKER'S COMP ☐ MEDICARE ☐

I WILL BE PAYING TODAY BY CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER ☐ OTHER ☐

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF ☐ SPOUSE ☐ OTHER ☐ CHILD ☐ SPOUSE: _____

INSURED'S EMPLOYER: SAME AS ABOVE ☐ _____

INSURED'S SSN SAME AS ABOVE ☐ SSN ____ - ____ - ____ INSURED'S DOB SAME AS ABOVE ☐ ___/___/___

PRIMARY INSURANCE CO._____ ADDRESS _____

CITY _____ STATE ____ ZIP CODE _____ PHONE#(_____)_____

POLICY NUMBER _____ GROUP NUMBER _____

****

SECONDARY INSURANCE CO._____ ADDRESS _____

CITY _____ STATE ____ ZIP CODE _____ PHONE#(_____)_____

POLICY NUMBER _____ GROUP NUMBER _____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

VERIFICATION OF INSURANCE BENEFITS

IF GROUP INSURANCE: Is there coverage for Chiropractic Care? **YES** ☐ **NO** ☐ **DATE** ___/___/___

Plan Administered by _____ Is Doctor **In Network** ☐ **Out of Network** ☐

Pre-Authorization Required? ? **YES** ☐ **NO** ☐

IN NETWORK BENEFITS

Amount of Deductible:$_____/Individual $_____/Family

Deductible met? **YES** ☐ **NO** ☐ $_____ Remaining

Deductible **Calendar** ☐ or **Fiscal** ☐ Renewal Date ___/___/___

Max. Yearly Benefit ? $ _____ Co-pay $_____ % Coverage ____

Max. Yearly Visit Limit? _____

Orthotics Coverage (CPT Code: L3030)? **YES** ☐ **NO** ☐ $_____

OUT OF NETWORK BENEFITS

Amount of Deductible:$_____/Individual $_____/Family

Deductible met? **YES** ☐ **NO** ☐ $_____ Remaining

Deductible **Calendar**☐ or **Fiscal** ☐ Renewal Date___/___/___

Max. Yearly Benefit ? $ _____ Co-pay $_____ % Coverage ____

Max. Yearly Visit Limit? _____

Orthotics Coverage (CPT Code: L3030)? **YES** ☐ **NO** ☐ $_____

Exclusions/Limitations: _____ Exclusions/Limitations: _____

Notes: _____

Spoke to Whom?_____ Mail Claims to: _____

Direct Telephone: _____ Address: _____

City _____ State _____ Zip _____

IF AUTO ACCIDENT

Who was found at fault / ticketed **Patient** ☐ **Other Driver** ☐

Insured Auto Insurance Carrier._____ Address _____

City _____ State _____ ZIP Code _____ Phone#(_____)_____

POLICY NUMBER _____ CLAIM NUMBER _____

Adjuster for the Claim? _____ Coverage Verified?_____

Deductible Amount? $_____ Spoke to Whom?_____

Does your auto insurance coverage have **Medical Payments** Coverage? **YES** ☐ **NO** ☐

If yes, Auto Insurance Carrier._____ Address _____

City _____ State _____ ZIP Code _____ Phone#(_____)_____

POLICY NUMBER _____ CLAIM NUMBER _____

Adjuster for the Claim? _____ Coverage Verified?_____

Deductible Amount? $_____ Spoke to Whom?_____

ATTORNEY'S NAME _____ PHONE#(_____)_____

IF WORKER'S COMPENSATION:

Employer's Name_____ Employer's #(_____)_____

Employer's Address:_____ Is patient Currently Employed at Same?_____

Has the injury been reported? **YES** ☐ **NO** ☐ Has care been authorized? ? **YES** ☐ **NO** ☐ By whom? _____

Employer's Insurance Carrier._____ Address _____

City _____ State _____ ZIP Code _____ Phone#(_____)_____

POLICY NUMBER _____ GROUP NUMBER _____

HEALTH QUESTIONNAIRE ○ Initial ○ Re-Eval

Use a **No. 2 pencil** to mark your answers. When marking in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭ **Erase** changes cleanly. Do **not fold** form.

Patient Name: _____

MO	DAY	YEAR	DR#	PATIENT NUMBER

A. PATIENT INFORMATION

Marital Status:
- ○ Single
- ○ Married
- ○ Separated
- ○ Divorced
- ○ Widowed

Sex: ○ M ○ F

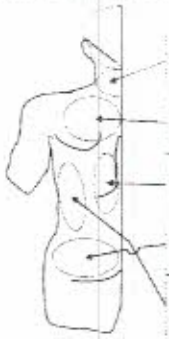
Children: ① ① ② ③ ④ ⑤

Patient Lives With:
- ○ Alone
- ○ Spouse
- ○ Children
- ○ Other
- ○ Parents
- ○ Roomate(s)
- ○ Assisted Living

B. PATIENT'S COMPLAINTS

1. Mark Your Present Complaints Below ○ Physical Examination with no complaints

Neck / Back

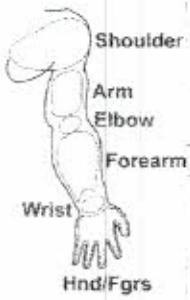


		Same As Left	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
Neck	Left		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Upr Back	Left		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Mid Back	Left		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Low Back	Left		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Ribs	Left		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R

When Did Your Neck/Back Complaints Begin?

○ Date: / /

Upper Extremities



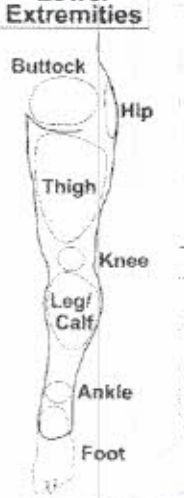
		Same As Above	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
LEFT	Shoulder		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Arm	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Elbow	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Forearm	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Wrist	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Hnd/Fgrs	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
RIGHT	Shoulder		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Arm	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Elbow	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Forearm	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Wrist	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Hnd/Fgrs	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R

When Did Your Upper Extremity Complaints Begin?

○ Same Date As Neck/Back

○ Different Date: / /

Lower Extremities



		Same As Above	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
LEFT	Hip		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Buttock	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Thigh	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Knee	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Leg/Calf	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Ankle	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Foot	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
RIGHT	Hip		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Buttock	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Thigh	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Knee	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Leg/Calf	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Ankle	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Foot	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R

When Did Your Lower Extremity Complaints Begin?

○ Same Date As Neck/Back

○ Different Date: / /

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617626

PLEASE MAKE NO MARKS IN THIS AREA

B. PATIENT'S COMPLAINTS (CONTINUED)

2. How Did Your Complaint(s) Begin[1]?
○ Unknown ○ Suddenly ○ Gradually

3. What Happened To Cause Or Re-Aggravate Your Complaint(s)?
○ Cause Not Known ○ Auto Accident
○ Work Accident/Injury ○ Home Accident
○ Personal Injury ○ Sport Injury
○ Other - Describe:

4. How Would You Rate Your Overall Pain Today Where 0 Is No Pain And 10 Is The Worst Pain[1]?
No Pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 Worst Pain Possible

5. When Are Your Symptoms Worse?
○ Morning ○ Afternoon ○ Evening ○ Night
○ Always The Same

6. What Makes Your Condition Better?
○ Nothing ○ Stretching ○ Heat
○ Rest ○ Exercise ○ Ice
○ Sitting ○ Standing ○ Medications
○ Other

7. What Makes Your Condition Worse?
○ Nothing ○ Coughing ○ Reaching ○ Standing
○ Sneezing ○ Lifting ○ Sitting ○ Pulling
○ Bending ○ Walking ○ Straining at Stool ○ Turning
○ Other

8. Have Any Of Your Complaint(s) Existed In The Past? ○ Yes ○ No
If Yes, Indicate Below
○ Neck ○ Upr Back ○ Mid Back ○ Low Back ○ Ribs
○ Shoulder ○ Arm ○ Elbow ○ Forearm ○ Wrist ○ Hnd/fgrs
○ Buttock ○ Hip ○ Thigh ○ Knee ○ Leg/calf ○ Ankle
○ Foot ○ Others:

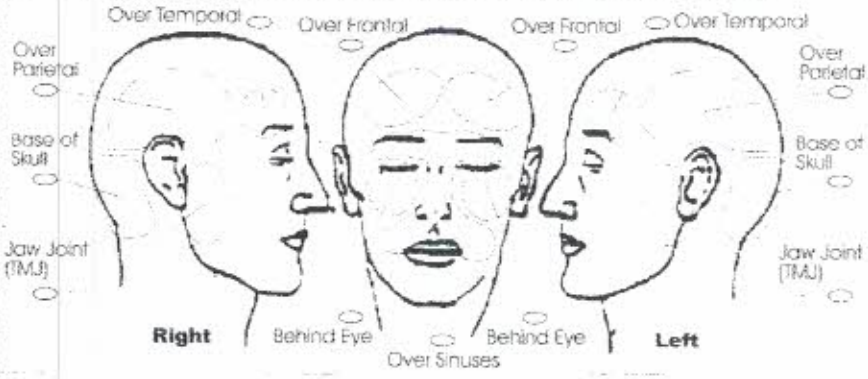
9. Have You Had Any Recent Treatment For Your Conditions OUTSIDE Of This Office[1]?
○ Yes ○ No If Yes, List Dates, Treatments, And Doctors.

10. Since Your Symptoms Began, Have You Noticed A Change In?
Bowel Function ○ Yes ○ No
Bladder Function ○ Yes ○ No ○ No To All
Sexual Function ○ Yes ○ No

C. HEADACHES

If You Are Experiencing Headaches, Please Fill Out This Section Otherwise Skip To Section D.

1. Where is The Pain Associated With Your Headaches Located?



2. On What Date Did Your Headaches Begin[1]?
○ Date: / / ○ Same As Neck/Back Complaints

3. How Does The Intensity Of Your Headaches Rate[1]?
No Pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 Worst Pain Possible

4. What Describes Your Pain?
○ Dull ○ Sharp ○ Aching ○ Stabbing
○ Deep ○ Vice-Like ○ Burning ○ Throbbing/Pulsating
○ Other

5. When Do Your Headaches Usually Start?
○ Constant/Anytime Awake ○ Wake Up With In Morning
○ At Midday ○ During Evening

6. What Seems To Bring On Your Headaches?
○ Physical Activity ○ Caffeine
○ Excessive Stress ○ Certain Foods
○ Alcohol ○ Menstrual Period
○ Other

7. How Often Do They Occur[1]?
Times/Week: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9
Times/Month: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9
○ Other

8. How Long Do Your Headaches Last[1]?
○ Less Than 1 Hour ○ From 1-3 Hours
○ Longer Than 3 Hours ○ All Waking Hours
○ Several Hours To Days
○ Other

9. Do Your Headaches Wake You From Sleep[1]?
○ No ○ Sometimes ○ Always

10. Do Any Of The Following Occur With Your Headaches?
○ Nausea/Vomiting ○ Weakness
○ Tremor ○ Vision Problems
○ Dizziness ○ Light/Sound Sensitivity
○ Other

11. What Makes Your Headaches Better?
○ Nothing ○ Rest ○ Lying Down ○ Ice/Cold Packs
○ Massage ○ Standing ○ NSAIDS (Aspirin, Tylenol, etc.)
○ Other

D. OTHER COMPLAINTS

Do you have any other complaints not covered on this form[1]? ○ Yes ○ No
If Yes, Describe other complaints in detail and mark body areas on Figures. ⟶

HEALTH QUESTIONNAIRE-HISTORY

Patient's Name

E. REVIEW OF SYSTEMS

Are You Currently Suffering From Any Of The Symptoms Listed Below? If This Is A Re-Examination Mark Only New Symptoms Since Your Last Exam.

○ **None** Of The Symptoms Listed Below

○ **No New** Symptoms Since Your Last Exam

- ○ General Fatigue
- ○ Weakness
- ○ Fever (continuous)
- ○ Loss Of Sleep
- ○ Chills (continuous)
- ○ Weight Change (unplanned)
- ○ Night Sweats
- ○ Headaches
- ○ Dizziness
- ○ Fainting
- ○ Convulsions
- ○ Nervousness
- ○ Anxiety
- ○ Depression (prolonged)
- ○ Phobias (excessive fears)
- ○ Memory Loss Or Impairment
- ○ Mood Swings (excessive)

	Left	Right
Hearing Trouble	○	○
Ringing in Ears	○	○
Pain in Ears	○	○
Ear Discharge	○	○
Vision Trouble	○	○
Pain in Eyes	○	○
Eye Discharge	○	○

- ○ Nose/Sinus Pain
- ○ Excessive Drainage
- ○ Nose Bleeds (chronic)
- ○ Nasal Infections (chronic)
- ○ Absence Of Smell
- ○ Mouth Sores
- ○ Bleeding Gums
- ○ Enlarged Glands
- ○ Absence Of Taste
- ○ Abnormal Taste Sensation
- ○ Tonsillitis/Infected Tonsils
- ○ Difficulty With Swallowing
- ○ Heat/Cold Intolerance
- ○ Sugar In Urine
- ○ Goiter (enlargedThyroid gland)
- ○ Tremor (shaking)
- ○ Skin Rash
- ○ Redness Of Skin
- ○ Skin Itching
- ○ Skin Dryness
- ○ Eczema(red, inflamed skin)
- ○ Hair Changes (unplanned)
- ○ Nail Changes (unplanned)
- ○ Bruise Easily
- ○ Cough (chronic)
- ○ Wheezing (chronic)
- ○ Difficulty Breathing
- ○ Swollen Extremities
- ○ Blue Extremities
- ○ Varicosities (visible veins)
- ○ Rapid Heart Beat
- ○ Chest Pain
- ○ Heart Palpitations
- ○ Heart Murmur
- ○ Decreased Appetite
- ○ Increased Appetite
- ○ Abdominal Pain
- ○ Hemorrhoids
- ○ Excess Gas
- ○ Vomiting (excessive)
- ○ Diarrhea (excessive)
- ○ Constipation (excessive)
- ○ Heartburn/Indigestion
- ○ Painful Urination
- ○ Inability To Hold Urine
- ○ Frequent Urination
- ○ Urinary Retention
- ○ Bed-wetting
- ○ Irregular Menstruation
- ○ Painful Menstruation
- ○ Abnormal Vaginal Bleeding
- ○ Sterility
- ○ Impotence
- ○ Lumps In Breast(s)
- ○ Redness/Itching of Breast
- ○ Dimpling of Breast(s)
- ○ Discharge from Breast(s)
- ○ Breast Pain
- ○ Other (Please Describe)

F. HABITS/ACTIVITIES

What Are Your Current Habits?

	Never	<1	1-2	2-3	3-4	5+
Smoking (Packs Per Day)	○	○	○	○	○	○
Caffeinated Drinks (Glasses Per Day)	○	○	○	○	○	○
Alcohol Consumption (Glasses Per Day)	○	○	○	○	○	○

Drug/Substance Abuse.. No ○ Yes ○ If Yes, Discuss With Doctor

	Never	<1	1-2	2-3	3-4	5+
Exercise (Days Per Week)	○	○	○	○	○	○

Kinds Of Exercise You Do:

○ Walking ○ Jogging ○ Cycling ○ Swimming
○ Golf ○ Tennis ○ Strength Training
○ Other:

G. MEDICAL HISTORY

1.HEALTH CARE

a. Have You Ever Been To A Chiropractor? . . . . . Yes ○ No ○

b. Do You Have A Family Physician . . . . . Yes ○ No ○

Date Of Last Physical Exam:
Physician's Name:
Address:
Phone:( )

c. Have You Been Hospitalized In The Past? . . . Yes ○ No ○

Date & Reason For Hospitalization:

d. Have You Ever Had Surgery? . . . . . Yes ○ No ○

Date, Reason, Results Of Surgery:

e. Have You Ever Had A Serious Accident/Injury? Yes ○ No ○

List Date & Describe Injury:
○ Auto:
○ Work-Related:
○ Personal:
○ Sports Injury:
○ Other:

f. Are You Currently Taking Any Vitamins, Minerals, Or Herbs? (List Supplements) Yes ○ No ○

g. Are You Currently Taking Any Medications? Yes ○ No ○

For What Condition(s) Are You Taking Medication?
○ Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.):
○ Pain/Analgesics:
○ Anti-Depressants:
○ Muscle Relaxants:
○ Blood Pressure Pills:
○ Antibiotics:
○ Birth Control Pills:
○ Corticosteroid:
○ Other:

In The Past Have You Use Any Of The Following?
○ Birth Control Pills ○ Corticosteroid

h. Are You Allergic To Any Medications? . . . . . Yes ○ No ○

List Medications:

G. MEDICAL HISTORY - CONTINUED

1i. WOMEN ONLY:

	Yes	No
To Your Knowledge, Are You Pregnant?	○	○
If Pregnant In Past, Were Pregnancies Normal?	○	○
Are You Seeing An OB-GYN Regularly?	○	○

Number Of Births: ① ② ③ ④ ⑤ ○ Other:

Date Of Last Exam: _____

Physician's Name: _____

Address: _____

_____ Phone:( ) _____

2. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	High Blood Pres	Stroke	Kidney Disease	Anemia	Mental Illness	Headaches	Osteoporosis	Arthritis	Joint Problems	Scoliosis	Back Problems	Disc Problems	Congenital Defects	Genetic Disease	Other	Deceased?
Father	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③
Mother	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③
Brothers	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	
Sisters	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	
Children	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	① ② ③	

Describe Others: _____

3. Conditions Or Illnesses

Please Indicate If You Now Have or Have Had In The Past Any Of The Following Illnesses:

○ ***No Current Or Previous Conditions/Illnesses***

Now Have	In Past		Now Have	In Past	
①	②	Sinus Trouble	①	②	Kidney Trouble
①	②	Hay Fever	①	②	Urinary Retention
①	②	Allergies	①	②	Frequent Urination
①	②	Asthma	①	②	Prostate Trouble
①	②	Emphysema	①	②	Arthritis
①	②	Tuberculosis	①	②	Osteoporosis
①	②	History of Infection	①	②	Scoliosis
①	②	Fever (Continuous)	①	②	Dislocated Joints
①	②	Cancer/Tumor	①	②	Spinal Disc Disease
①	②	Diabetes	①	②	Bone Fracture (list/dates):
①	②	Visual Disturbances			
①	②	Dizziness/Fainting			
①	②	Epilepsy/Seizures			
①	②	Thyroid Trouble	①	②	Mental/Emotional Difficulty
①	②	High Blood Pressure	①	②	Sex. Trans. Diseases
①	②	Low Blood Pressure	①	②	HIV
①	②	Heart Trouble	①	②	AIDS/ARC
①	②	Pacemaker	①	②	Abnormal Weight Gain
①	②	Stroke [date_____]	①	②	Abnormal Weight Loss
①	②	Aortic Aneurysm	①	②	Numbness Groin/Buttocks
①	②	Anemia	①		Other: _____
①	②	Rheumatic Fever			
①	②	Polio			
①	②	Multiple Sclerosis		②	Other: _____
①	②	Ulcer			
①	②	Liver Trouble			

H. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING

1. Are You Right Or Left Handed? ○ Right ○ Left

2. Job Type

○ Retired ○ Unemployed ○ Full-Time Student

If Any Of Above Skip Rest, Sign At Patient's Signature

○ Full Time ○ Part Time ○ Temporary

○ Self-Employed ○ Other _____

3. During Your Work Week, You Work How Many:

Hours Per Day ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫

Days Per Week ① ② ③ ④ ⑤ ⑥ ⑦

○ Other _____

4. How Long Have You Been With Your Present Employer?

Years ⑩ ⑳ ㉚ ㊵ ㊿ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Months ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪

5. Do Your Present Complaints Affect The Number Of Hours You Work Per Day? ○ Yes ○ No

6. What Is Your Primary Work Position and Location?

a. Work Position: ○ Seated ○ Standing ○ Other _____

b. Work Location: ○ Desk ○ Counter ○ Workbench ○ Other _____

7. What Movements Does Your Job Require?

○ Bending ○ Turning ○ Stooping

○ Twisting ○ Walking ○ Repetitive Hand Use

○ Carrying ○ Other _____

8. Does Your Work Include Any Of The Following Use?

○ Prolonged Computer ○ Continuous Phone

9. Does Your Job Involve Lifting?

○ Never ○ Occasionally ○ Intermittently

○ Frequently ○ Constantly

How Many Pounds? (Choose Only One) 10 20 30 40 50 60 70 80 90 100+ ○ Pounds

10. What Best Describes Your Stress Level At Work?

○ None ○ Minimal ○ Minimal To Moderate

○ Moderate ○ Moderate To Extreme ○ Extreme

11. How Do You Rate Your Physical Activity At Work?

○ Seated more than 50% of workday

Manual Labor: ○ Light ○ Light To Moderate ○ Moderate ○ Moderate To Heavy ○ Heavy

12. Do Work Activities Aggravate Your Present Complaints?

○ Yes ○ No **If Yes, Explain:** _____

PATIENT'S SIGNATURE _____ **DATE:** _____

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EW-239467-2:22

HEALTH STATUS QUESTIONNAIRE

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER

Please Read: This survey asks for your views about your health. The information will help your health care provider track how you feel and how well you are able to do your usual activities.

Answer every question by filling in the appropriate bubble. If you are unsure about how to answer a question, please give the best answer you can and make a comment at the end of the questionnaire.

Please use a **No. 2 pencil** to fill in your answers.
Fill in bubbles **completely** as indicated here: ⬭
Erase changes cleanly. Do **not fold** this form.

A. In general, would you say your health is:
[MARK ONLY ONE ANSWER]

- Excellent
- Very good
- Good
- Fair
- Poor

B. Compared to one year ago, how would you rate your health in general now? [MARK ONLY ONE ANSWER]

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same
- Somewhat worse now than one year ago
- Much worse now than one year ago

C. The following items are about activities you might do during a typical day.

Does your health now limit you in these activities? If so, how much?
[MARK ONLY ONE ANSWER ON EACH LINE]

	Yes, limited a lot	Yes, limited a little	No, not limited at all
1. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports			
2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf			
3. Lifting or carrying groceries			
4. Climbing several flights of stairs			
5. Climbing one flight of stairs			
6. Bending, kneeling, or stooping			
7. Walking more than a mile			
8. Walking several blocks			
9. Walking one block			
10. Bathing or dressing yourself			

D. During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

[MARK EITHER YES OR NO ON EACH LINE]

	Yes	No
1. Cut down the amount of time you spent on work or other activities		
2. Accomplished less than you would like		
3. Were limited in the kind of work or other activities		
4. Had difficulty performing the work or other activities (for example, it took extra effort)		

E. During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

[MARK EITHER YES OR NO ON EACH LINE]

	Yes	No
1. Cut down the amount of time you spent on work or other activities		
2. Accomplished less than you would like		
3. Didn't do work or other activities as carefully as usual		

F. During the past four weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

[MARK ONLY ONE ANSWER]

- Not at all
- Slightly
- Moderately
- Quite a bit
- Extremely

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HEALTH STATUS QUESTIONNAIRE (CONTINUED)

G. How much bodily pain have you had during the past four weeks?
[MARK ONLY ONE ANSWER]

- ① None
- ② Very mild
- ③ Mild
- ④ Moderate
- ⑤ Severe
- ⑥ Very severe

H. During the past four weeks how much did pain interfere with your normal work (including both work outside the home and housework?)
[MARK ONLY ONE ANSWER]

- ① Not at all
- ② A little bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

I. These questions are about how you feel and how things have been with you during the past four weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past four weeks . . . . .
[MARK ONLY ONE ANSWER ON EACH LINE]

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
1. Did you feel full of pep?	①	②	③	④	⑤	⑥
2. Have you been a very nervous person?	①	②	③	④	⑤	⑥
3. Have you felt so down in the dumps that nothing could cheer you up?	①	②	③	④	⑤	⑥
4. Have you felt calm and peaceful?	①	②	③	④	⑤	⑥
5. Did you have a lot of energy?	①	②	③	④	⑤	⑥
6. Have you felt downhearted and blue?	①	②	③	④	⑤	⑥
7. Did you feel worn out?	①	②	③	④	⑤	⑥
8. Have you been a happy person?	①	②	③	④	⑤	⑥
9. Did you feel tired?	①	②	③	④	⑤	⑥

J. During the past four weeks how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?
[MARK ONLY ONE ANSWER]

- ① All of the time
- ② Most of the time
- ③ Some of the time
- ④ A little of the time
- ⑤ None of the time

K. How TRUE or FALSE is each of the following statements for you?

[MARK ONLY ONE ANSWER ON EACH LINE]

	Definitely true	Mostly true	Don't Know	Mostly false	Definitely false
1. I seem to get sick a little easier than other people.	①	②	③	④	⑤
2. I am as healthy as anybody I know.	①	②	③	④	⑤
3. I expect my health to get worse.	①	②	③	④	⑤
4. My health is excellent.	①	②	③	④	⑤

L. Please answer YES or NO

[MARK ONLY ONE ANSWER ON EACH LINE]

	Yes	No
1. In the past year, have you had two weeks or more during which you felt sad, blue, or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed?	①	②
2. Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?	①	②
3. Have you felt depressed or sad much of the time in the past year?	①	②

Additional Comments:

SIGNATURE:

DATE:

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities.

Please answer **each section** by darkening the **one bubble** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **please, just pencil in the one choice which closely describes your problem now.**

Please use a **No. 2 pencil** to fill in your answer.
Fill in bubbles **completely** as indicated here:
Erase changes cleanly. Do **not fold** this form.

1. 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.

2. 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.

3. 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 can 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 lift very light weights.
- I cannot lift or carry anything at all.

4. 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 with moderate pain in my neck.
- I cannot read as much as I want because of moderate pain in my neck.
- I cannot read as much as I want because of severe pain in my neck.
- I cannot read at all.

5. HEADACHES

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

After Vernon & Mior, 1991
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6. 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.

7. WORK

- I can do as much work as I want to.
- I can only 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 cannot do any work at all.

8. 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 cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I cannot drive my car at all.

9. SLEEPING

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

10. RECREATION

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

SIGNATURE: **DATE:**

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

Patient Name: _____

MO DAY YEAR | DR# | PATIENT NUMBER

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities.

Please answer each section by darkening the **one bubble** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **please, just pencil in the one choice which most closely describes your problem right now**.

Please use a **No. 2 pencil** to fill in your answers.
Fill in bubbles **completely** as indicated here:
Erase changes cleanly. Do **not fold** this form.

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

1. 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.

2. 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.

3. 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.

4. 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 1/2 mile.
- (D) Pain prevents me from walking more than 1/4 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.

5. 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 1/2 hour.
- (E) Pain prevents me from sitting more than ten minutes.
- (F) Pain prevents me from sitting at all.

6. 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 1/2 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.

7. 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.

8. 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.

9. 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.

10. 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.

SIGNATURE: DATE:

ROLAND-MORRIS ACUTE LOW BACK PAIN DISABILITY QUESTIONNAIRE

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER

Please Read: When your back hurts, you may find it difficult to do some of the things you normally do.

This list contains some sentences that people have used to describe themselves when they have back pain. When you read them you may find that some stand out because they describe you today.

As you read the list, think of yourself today. Mark the bubble next to any sentence that describes you today. If the sentence does not describe you, then leave the bubble blank and go on to the next one.

Remember, only mark the sentence if you are sure that it describes you today.

Please use a **No. 2 pencil** to fill in your answers.
Fill in bubbles **completely** as indicated here:
Erase changes cleanly. Do **not fold** this form.

- ① **I stay at home most of the time because of my back.**
- ② **I change position frequently to try and get my back comfortable.**
- ③ **I walk more slowly than usual because of my back.**
- ④ **Because of my back I am not doing any of the jobs that I usually do around the house.**
- ⑤ **Because of my back, I use a handrail to get upstairs.**
- ⑥ **Because of my back, I lie down to rest more often.**
- ⑦ **Because of my back, I have to hold on to something to get out of any easy chair.**
- ⑧ **Because of my back, I try to get other people to do things for me.**
- ⑨ **I get dressed more slowly than usual because of my back.**
- ⑩ **I only stand up for short periods of time because of my back.**
- ⑪ **Because of my back, I try not to bend or kneel down.**
- ⑫ **I find it difficult to get out of a chair because of my back.**
- ⑬ **My back is painful almost all the time.**
- ⑭ **I find it difficult to turn over in bed because of my back.**
- ⑮ **My appetite is not very good because of my back.**
- ⑯ **I have trouble putting on my socks (or stockings) because of the pain in my back.**
- ⑰ **I only walk short distances because of my back pain.**
- ⑱ **I sleep less well because of my back.**
- ⑲ **Because of my back pain, I get dressed with help from someone else.**
- ⑳ **I sit down for most of the day because of my back.**
- ㉑ **I avoid heavy jobs around the house because of my back.**
- ㉒ **Because of my back pain, I am more irritable and bad tempered with people than usual.**
- ㉓ **Because of my back, I go upstairs more slowly than usual.**
- ㉔ **I stay in bed most of the time because of my back.**

SIGNATURE: _____ **DATE:** _____

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Appendix 1: Disability Questionnaire from "A Study of the Natural History of a Reliable and Sensitive Measure of Disability in Low Back Pain." Spine 1983, 8(2): 141-4

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ACCIDENT / INJURY QUESTIONNAIRE

Dear Patient:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU.

Use a **No. 2 pencil** to mark your answers. When marking in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭. **Erase** changes cleanly. Do **not fold** form.

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER

A. DATE AND TIME OF ACCIDENT / INJURY

⬭ Date: Time: : am / pm

B. DESCRIPTION OF ACCIDENT / INJURY

⬭ Automobile Crash Questionnaire Marked **(Skip Section B)**
⬭ Workmen's Compensation Accident / Injury
⬭ Slip/Fall Accident ⬭ Pedestrian Accident
Other: ⬭ Accident ⬭ Injury

1. What was the cause of your accident / injury?

2. Describe in your own words what happened:

C. IMMEDIATELY AFTER ACCIDENT / INJURY

1. Did you lose consciousness?
⬭ Yes ⬭ No ⬭ Don't Know

2. How did you feel?
⬭ Confused ⬭ Dazed ⬭ Dizzy ⬭ Nervous
⬭ Weak ⬭ Other

3. Where did you immediately develop pain?

⬭ Head	⬭ Shoulders	⬭ Buttocks
⬭ Neck	⬭ Arms	⬭ Hips
⬭ Upper / Mid Back	⬭ Elbows	⬭ Thighs
⬭ Lower Back	⬭ Forearms	⬭ Knees
⬭ Pelvis	⬭ Wrists	⬭ Legs
⬭ Chest / Rib Cage	⬭ Hands	⬭ Ankles
⬭ Abdomen		⬭ Feet
⬭ Other		

4. If there were lacerations (cuts), where were they?

⬭ Head	⬭ Shoulders	⬭ Buttocks
⬭ Neck	⬭ Arms	⬭ Hips
⬭ Upper / Mid Back	⬭ Elbows	⬭ Thighs
⬭ Lower Back	⬭ Forearms	⬭ Knees
⬭ Pelvis	⬭ Wrists	⬭ Legs
⬭ Chest / Rib Cage	⬭ Hands	⬭ Ankles
⬭ Abdomen		⬭ Feet
⬭ Other		

5. Describe any other significant injury:

6. Emergency Care At Accident/Injury Site
a. Did you receive emergency care? ⬭ Yes ⬭ No

b. What type of emergency care did you receive?
⬭ Bandages ⬭ Splints ⬭ Brace ⬭ Neck Collar
⬭ Other

7. Destination After Accident / Injury

a. Where did you go?		b. By whom were you driven?	
⬭ Hospital	⬭ Home	⬭ Myself	⬭ Ambulance
⬭ School	⬭ Work	⬭ Friend	⬭ Family Member
⬭ Other		⬭ Other	

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

1. When did you go to the hospital?
⬭ Immediately ⬭ Later That Day ⬭ Next Day ⬭ Days Later
⬭ Date ⬭ Other

⬭ Hospital Name: ⬭ Examined By Doctor:

Admitted: ⬭ Yes ⬭ No ⬭ Date Discharged:

2. If x-rays were taken, of what body part(s)?

⬭ Head	⬭ Shoulders	⬭ Buttocks
⬭ Neck	⬭ Arms	⬭ Hips
⬭ Upper / Mid Back	⬭ Elbows	⬭ Thighs
⬭ Lower Back	⬭ Forearms	⬭ Knees
⬭ Pelvis	⬭ Wrists	⬭ Legs
⬭ Chest / Rib Cage	⬭ Hands	⬭ Ankles
⬭ Abdomen		⬭ Feet
⬭ Other		

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D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

3. If a CAT Scan was performed, of what body part(s)?

Head | Upper / Mid Back | Chest / Rib Cage
Neck | Lower Back | Abdomen
Other

4. If a MRI was performed, of what body part(s)?

Head | Upper / Mid Back | Chest / Rib Cage
Neck | Lower Back | Abdomen
Other

5. What was the diagnosis given at the hospital?

a. Head
Concussion | Skull Fracture | Lacerations
Contusions | Other

b. Jaw
Strain | Sprain | Dislocation
Fracture | Whiplash | Lacerations
Contusions | Other

c. Neck
Strain | Sprain | Dislocation
Fracture | Whiplash | Disc Injury
Lacerations | Contusions
Other

d. Upper / Middle Back
Strain | Sprain | Dislocation
Fracture | Disc Injury | Lacerations
Contusions | Other

e. Lower Back
Strain | Sprain | Dislocation
Fracture | Disc Injury | Lacerations
Contusions | Other

f. Pelvis
Strain | Sprain | Dislocation
Fracture | Lacerations | Contusions
Other

g. Chest / Rib Cage
Strain | Sprain | Dislocation
Fracture | Lacerations | Contusions
Other

h. Abdomen
Strain | Lacerations | Contusions
Other

i. Shoulders
Strain | Sprain | Dislocation
Fracture | Lacerations | Contusions
Other

j. Arms
Strain | Sprain | Dislocation
Fracture | Lacerations | Contusions
Other

k. Elbows
Strain | Sprain | Dislocation
Fracture | Lacerations | Contusions
Other

l. Forearms
Strain | Sprain | Dislocation
Fracture | Lacerations | Contusions
Other

m. Wrists
Strain | Sprain | Dislocation
Fracture | Lacerations | Contusions
Other

n. Hands / Fingers
Strain | Sprain | Dislocation
Fracture | Lacerations | Contusions
Other

o. Buttocks
Strain | Sprain | Lacerations
Contusions | Other

p. Hips
Strain | Sprain | Dislocation
Fracture | Lacerations | Contusions
Other

q. Thighs
Strain | Sprain | Dislocation
Fracture | Lacerations | Contusions
Other

r. Knees
Strain | Sprain | Dislocation
Fracture | Lacerations | Contusions
Other

s. Legs
Strain | Sprain | Dislocation
Fracture | Lacerations | Contusions
Other

t. Ankles
Strain | Sprain | Dislocation
Fracture | Lacerations | Contusions
Other

u. Feet / Toes
Strain | Sprain | Dislocation
Fracture | Lacerations | Contusions
Other

v. Other
Strain | Sprain | Dislocation
Fracture | Lacerations | Contusions

w. Describe any additional diagnosis given:

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

6. What treatment was administered at the hospital?

- Oral Medication
- Sutures
- Splint
- Collar
- Injection
- Ice Packs
- Cast
- Support
- Topical Antiseptics
- Hot Packs
- Brace
- Surgery
- Bandages
- Other

7. Instructions Given When Discharged From Hospital

a. Were you told to see?

- General Practitioner
- Chiropractor
- Neurologist
- Physical Therapist
- Orthopedist
- Internist
- General Surgeon
- Plastic Surgeon
- Other

b. What recommendations were made?

- No Further Care
- No Follow-up Instructions
- Observation
- Rest
- Ice
- Heat
- Collar
- Support
- Time Off Work
- Other

c. Were medications prescribed?

- Pain
- Anti-inflammatory
- Antibiotic
- Nervousness
- Other

E. FOLLOWING THE ACCIDENT / INJURY

1. How much later did additional symptoms develop?

- Immediately
- Hours
- That Evening
- Next Morning
- Days
- Week
- Month

2. What additional symptoms developed?

a. Head
Pain Stiffness Numbness Tingling Other

b. Jaw
Pain Stiffness Numbness Tingling Other

c. Neck
Pain Stiffness Numbness Tingling Other

d. Upper / Middle Back
Pain Stiffness Numbness Tingling Other

e. Lower Back
Pain Stiffness Numbness Tingling Other

f. Pelvis
Pain Stiffness Numbness Tingling Other

g. Chest / Rib Cage
Pain Stiffness Numbness Tingling Other

h. Abdomen
Pain Stiffness Numbness Tingling Other

i. Shoulders
R L Pain R L Stiffness R L Numbness R L Tingling R L Other

j. Arms
R L Pain R L Stiffness R L Numbness R L Tingling R L Other

k. Elbows
R L Pain R L Stiffness R L Numbness R L Tingling R L Other

l. Forearms
R L Pain R L Stiffness R L Numbness R L Tingling R L Other

m. Wrists
R L Pain R L Stiffness R L Numbness R L Tingling R L Other

n. Hands / Fingers
R L Pain R L Stiffness R L Numbness R L Tingling R L Other

o. Buttocks
R L Pain R L Stiffness R L Numbness R L Tingling R L Other

p. Hips
R L Pain R L Stiffness R L Numbness R L Tingling R L Other

q. Thighs
R L Pain R L Stiffness R L Numbness R L Tingling R L Other

r. Knees
R L Pain R L Stiffness R L Numbness R L Tingling R L Other

s. Legs
R L Pain R L Stiffness R L Numbness R L Tingling R L Other

t. Ankles
R L Pain R L Stiffness R L Numbness R L Tingling R L Other

u. Feet / Toes
R L Pain R L Stiffness R L Numbness R L Tingling R L Other

v. Other

3. Since your accident / injury have you suffered from?

- Blurred Vision
- Chest Pain
- Nausea
- Double Vision
- Difficulty Breathing
- Vomiting
- Reduced Vision
- Palpitations
- Frequent Urination
- Impaired Hearing
- Constipation
- Inability To Hold Urine
- Ringing In Ears
- Diarrhea
- Painful Urination

E. FOLLOWING THE ACCIDENT/INJURY (Continued)

4. Additionally have you experienced any of the following?

- ⬭ Anxiety
- ⬭ Depression
- ⬭ Mood Swings
- ⬭ Nervousness
- ⬭ Poor Memory
- ⬭ Tension
- ⬭ Other _____
- ⬭ Convulsions
- ⬭ Dizziness
- ⬭ Headaches
- ⬭ Fainting
- ⬭ Loss Of Balance
- ⬭ Fatigue
- ⬭ Restlessness
- ⬭ Insomnia
- ⬭ Light Sensitivity
- ⬭ Reduced Appetite
- ⬭ Weakness
- ⬭ Weight Gain
- ⬭ Weight Loss

5. Are you restricted in any of the following areas as a result of this accident/injury?

⬭ Daily Living ⬭ Occupational/Work ⬭ Recreational Activities
⬭ Other _____

6. Have you missed work due to this accident / injury?

⬭ Missed No Work ⬭ Limited Work Activity
⬭ Missed Work From: _____ To: _____
⬭ Other _____

7. Did you self treat your symptoms?

⬭ Ice ⬭ Heat ⬭ Bed Rest ⬭ Over-The-Counter Medication
⬭ Other _____

8. Did you seek medical care elsewhere?

a. General Practitioner ⬭ Name:
⬭ Diagnosis And Treatment Recommendation:

b. Internist ⬭ Name:
⬭ Diagnosis And Treatment Recommendation:

c. Chiropractor ⬭ Name:
⬭ Diagnosis And Treatment Recommendation:

d. Neurologist ⬭ Name:
⬭ Diagnosis And Treatment Recommendation:

e. Orthopedist ⬭ Name:
⬭ Diagnosis And Treatment Recommendation:

f. General Surgeon ⬭ Name:
⬭ Diagnosis And Treatment Recommendation:

g. Plastic Surgeon ⬭ Name:
⬭ Diagnosis And Treatment Recommendation:

h. Psychologist ⬭ Name:
⬭ Diagnosis And Treatment Recommendation:

i. Other ⬭ Name: ⬭ Type:
⬭ Diagnosis And Treatment Recommendation:

9. Have you had any of the following tests?

⬭ CT Scan ⬭ MRI ⬭ Electrodiagnostic Studies
⬭ Other _____

10. What is the reason for seeking today's consultation?

⬭ Persisting Complaints ⬭ Worsening Of Symptoms
⬭ Other _____

F. INSURANCE / ATTORNEY INFORMATION

1. Have you contacted an insurance adjuster or representative regarding this claim? Yes ⬭ No ⬭

Company:
Adjuster:
Claim #:

2. Have you engaged services of an attorney? Y ⬭ N ⬭

Attorney: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____

3. Have you filed an accident / injury report? Y ⬭ N ⬭

4. Have you filed for insurance benefits? Y ⬭ N ⬭

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Patient's Or Guardian Signature: **Date:**

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AUTOMOBILE CRASH QUESTIONNAIRE

Dear Patient:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU.

Use a **No. 2 pencil** to mark your answers. When marking in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭. **Erase** changes cleanly. Do **not fold** form.

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER

A. VEHICLE YOU WERE IN

1. Vehicle type?
⬭ Car ⬭ Pickup
⬭ Van ⬭ Truck
⬭ Station Wagon ⬭ Bus
⬭ Other

2. Vehicle size?
⬭ Subcompact ⬭ Full-Size
⬭ Compact ⬭ Mini
⬭ Mid-Size ⬭ Light
⬭ Other

3. What was your location in the vehicle?
⬭ Driver ⬭ Front Passenger ⬭ Rear Passenger
Passenger Location: ⬭ Left ⬭ Middle ⬭ Right
⬭ Other

4. What was the vehicle you were in doing?
Mark only ONE bubble below to answer this question

a. Vehicle stopped for
⬭ Traffic Light ⬭ Intersection ⬭ Stop Sign ⬭ Traffic
⬭ Pedestrian ⬭ Parked
⬭ Other

b. Vehicle slowing down for
⬭ Traffic Light ⬭ Intersection ⬭ Stop Sign ⬭ Traffic
⬭ Pedestrian ⬭ Turning ⬭ Parking
⬭ Other

c. Vehicle moving
⬭ Slowly ⬭ Moderately ⬭ Fast
⬭ MPH ⬭ Accelerating
⬭ Other

d. Vehicle doing other
⬭ Other

5. What damage did the vehicle you were in sustain?
⬭ Minimal ⬭ Moderate ⬭ Extensive ⬭ Totaled
⬭ Unsure ⬭ Other

B. IF OTHER VEHICLES INVOLVED IN ACCIDENT

1. First Vehicle To Strike Vehicle You Were In

a. Vehicle type?
⬭ Car ⬭ Pickup
⬭ Van ⬭ Truck
⬭ Station Wagon ⬭ Bus
⬭ Other

b. Vehicle size?
⬭ Subcompact ⬭ Full-Size
⬭ Compact ⬭ Mini
⬭ Mid-Size ⬭ Light
⬭ Other

c. How did this vehicle strike the vehicle you were in?
⬭ Head On ⬭ From Right ⬭ From Left ⬭ Rear Ended
⬭ Sideswiped On Right ⬭ Sideswiped On Left
⬭ Other

d. What damage did this vehicle sustain?
⬭ Minimal ⬭ Moderate ⬭ Extensive ⬭ Totaled
⬭ Unsure ⬭ Other

2. Second Vehicle To Strike Vehicle You Were In

a. Vehicle type?
⬭ Car ⬭ Pickup
⬭ Van ⬭ Truck
⬭ Station Wagon ⬭ Bus
⬭ Other

b. Vehicle size?
⬭ Subcompact ⬭ Full-Size
⬭ Compact ⬭ Mini
⬭ Mid-Size ⬭ Light
⬭ Other

c. How did this vehicle strike the vehicle you were in?
⬭ Head On ⬭ From Right ⬭ From Left ⬭ Rear Ended
⬭ Sideswiped On Right ⬭ Sideswiped On Left
⬭ Other

d. What damage did this vehicle sustain?
⬭ Minimal ⬭ Moderate ⬭ Extensive ⬭ Totaled
⬭ Unsure ⬭ Other

3. Describe Other Vehicles To Strike Vehicle You Were In
⬭ Vehicle Type: ⬭ How it struck:
⬭ Vehicle Size: ⬭ Damage:

4. Were traffic citations issued as a result of the accident?
⬭ No Citations issued ⬭ Driver Of Other Vehicle
⬭ Driver Of Vehicle You Were In ⬭ You ⬭ Unsure

C. CONDITIONS AT TIME OF ACCIDENT

1. What time of day did the accident occur?
⬭ Daylight ⬭ Dawn ⬭ Dusk ⬭ Night
⬭ Other

2. What was the condition of the road?
⬭ Dry ⬭ Damp ⬭ Wet ⬭ Snow Covered
⬭ Icy ⬭ Other

3. Visibility

a. What was the visibility at impact?
⬭ Good ⬭ Fair ⬭ Poor
⬭ Other

b. If visibility was poor, why?
⬭ Sun Light ⬭ Darkness ⬭ Rain ⬭ Snow
⬭ Fog ⬭ Traffic
⬭ Other

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D. AT MOMENT OF IMPACT

1. Were you prepared for the accident?
   - Accident A Complete Surprise
   - Aware Of Impending Collision
   - And Braced For Impact

2. Foot On Brake Pedal
   a. Was your foot on brake pedal at impact? Yes No
   b. Was it knocked off pedal by impact? Yes No

3. Use Of Restraints
   a. Restraint Belts
      1. Were you wearing a restraint belt? Yes No
      2. What type of restraint belt were you wearing?
         Shoulder-Lap Belt Shoulder Belt Lap Belt
   b. Headrests
      1. Was vehicle equipped with headrests? Yes No
      2. What position was the headrest in?
         Low Middle High Don't Know
   c. Air Bags
      1. Was vehicle equipped with air bags?
         Yes No Unsure
      2. Did the air bags deploy? Yes No

4. Your Body
   a. What was your body position at impact?
      Straight Slouched Forward **Rotated:** Right Left
      Don't Recall Other
   b. What direction was your body thrown?
      Forward\Backward Backward\Forward Sideways
      Across Vehicle Outside Vehicle Under Vehicle
      Don't Recall Other

5. Your Head And Neck
   a. What position were your head/neck in at impact?
      Straight Tilted Forward **Rotated:** Right Left
      Don't Recall Other
   b. Through what motion were your head/neck pitched?
      Forward\Backward Backward\Forward Sideways
      Don't Recall Other

E. RESULT OF IMPACT

1. Which objects in the vehicle did the force of the collision cause your body to strike?
   a. Head
      Steering Wheel Dashboard Windshield
      Right Side Door Left Side Door Armrest
      Right Window Left Window Headrest
      Ceiling Console Shift Lever
      Front Seat Rear View Mirror
      Other
   b. Right Upper Extremity (Arm)
      Steering Wheel Dashboard Windshield
      Right Side Door Left Side Door Armrest
      Right Window Left Window Headrest
      Ceiling Console Shift Lever
      Front Seat Rear View Mirror
      Other
   c. Left Upper Extremity (Arm)
      Steering Wheel Dashboard Windshield
      Right Side Door Left Side Door Armrest
      Right Window Left Window Headrest
      Ceiling Console Shift Lever
      Front Seat Rear View Mirror
      Other
   d. Torso
      Steering Wheel Dashboard Windshield
      Right Side Door Left Side Door Armrest
      Right Window Left Window Headrest
      Ceiling Console Shift Lever
      Front Seat Rear View Mirror
      Other
   e. Right Lower Extremity (Leg)
      Steering Wheel Dashboard Windshield
      Right Side Door Left Side Door Armrest
      Right Window Left Window Headrest
      Ceiling Console Shift Lever
      Front Seat Rear View Mirror
      Other
   f. Left Lower Extremity (Leg)
      Steering Wheel Dashboard Windshield
      Right Side Door Left Side Door Armrest
      Right Window Left Window Headrest
      Ceiling Console Shift Lever
      Front Seat Rear View Mirror
      Other

2. Did your body strike any other objects?
   Description Of Other Objects Your Body Hit

F. ADDITIONAL INFORMATION

Additional Information About Your Automobile Accident:

Patient's Or Guardian Signature: **Date:**

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