

Patient Questionnaire – Auto-Accident

Patient Name: _____ Today's Date: ___/___/___

Date of Exam: ___/___/___ Provider: _____ New Patient Yes No

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___ Time of Day when Accident Occurred or Started: ___:___ AM / PM

Describe how the Accident took place: _____

Describe the condition or symptoms caused by the Accident: _____

Auto-Accident Specific Information:

Were you the: Driver Passenger Pedestrian

Automobile you were in: Year _____ Make _____ Model _____

Damage to your car: Front Rear Pedestrian Driver Side Passenger Side Bumper Fender

Damage Amount Estimate: \$ _____ : Minor Major Totaled

Other Automobile: Year _____ Make _____ Model _____

Damage to other car: Front Rear Pedestrian Driver Side Passenger Side Bumper Fender
 Minor Major Totaled

Where did the accident happen? Street Names: _____ City/State _____

Was it? Controlled Intersection Uncontrolled Not Intersection

Was there a traffic light? None Green Red Turn Arrow Stop Sign

Were you: Slowly Moving Moving Stopped

Weather Conditions: Sunny Rainy Cloudy

Street Surface: Dry Wet Slick Icy Pavement Other _____

Type of Impact: Rear end Front Side Impact Roll Over

Brakes on Impact: Locked Tight Loosely Applied Foot not on brake

How far did your car move? Did not move Moved 1-5 ft Moved 6-10 ft Moved over 10 ft

Where were you seated in the vehicle: _____ Wearing Seat belt? Yes No

Shoulder harness: Yes No Headrest: Yes No Headrest Position: Up Down

Is the car equipped with airbags? Yes No Did they deploy? Yes No

Did you see the impact coming? Yes No Did you brace yourself for impact? Yes No

On impact, your head was looking: Ahead Behind Up Down To the Right To the Left

On impact were you: Thrown forward Thrown backwards Thrown sideways Other _____

Did your body hit anything inside the car? Yes No Body Part: _____

What did it hit? _____

Head trauma? Yes No Loss of Consciousness? Yes No For how long? _____
 Do you remember the accident happening? Yes No
 Hospital? Yes No Name of hospital: _____ How long there? _____
 Taken by ambulance? Yes No
 X-rays taken? Yes No X-ray areas: Neck Mid-back Low-back Other X-rays _____
 Medication Given? Yes No RX: _____
 Other instruction: _____ Follow-up: _____

Additional Information Related to the Condition:

Describe your pain: Burning Sharp Dull Ache
 What caused it? _____
 What aggravates it? _____
 What relieves it? _____
 Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? Yes No
 When? ___/___/___
 Describe: _____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Please check any of the following symptoms you are now experiencing:

- | | | | | | |
|--|--|--|--|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Tingling in arms/hands | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Tingling in legs/feet | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Nausea | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in legs/feet | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Chest pain/rib pain | <input type="checkbox"/> Pain in arms/hands | <input type="checkbox"/> Pain in legs/feet | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Loss of strength - arms | <input type="checkbox"/> Burning muscle pain | <input type="checkbox"/> Loss of strength - legs | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Sharp/shooting pain | |
- Other _____

Have you experienced changes to:

- | | | | | |
|---------------------------------------|---|---------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Eyes (sight) | <input type="checkbox"/> Ears (hearing) | <input type="checkbox"/> Nose (smell) | <input type="checkbox"/> Mouth (taste) | <input type="checkbox"/> Bladder |
| <input type="checkbox"/> Bowels | <input type="checkbox"/> Sleep | <input type="checkbox"/> Emotion | <input type="checkbox"/> Appetite | |

Please Explain: _____

Have you missed work or school due to your injuries? Yes No

Do you smoke? Yes No Number of packs: _____

Do you drink alcohol? Yes No Number of Drinks _____

Notes: _____

Medical History:

Have you ever been in our office before? Yes No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ / /

2) _____ / /

3) _____ / /

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

Do you now or have you ever had:

- | | | | | | |
|--|--|--|---------------------------------|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Prostate Disorder | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizure Disorder |

Other: _____

MEDICATION RECORD

PATIENT NAME: _____

DATE	NAME OF MEDICATION	STRENGTH	DOSE HOW OFTEN

ALLERGIES TO MEDICATIONS? YES NO (CIRCLE ONE)
NAME OF ALLERGY: _____

DOB: ___ / ___ / ___

GENDER: ___ MALE ___ FEMALE

PREFERRED LANGUAGE SPOKEN/USED: _____

RACE: _____

ETHNICITY: _____

DO NOT SMOKE? YES NO (CIRCLE ONE) IF YES , HOW LONG _____

Score: _____

The Neck Disability Index

Date: _____

Please rate the severity of your pain by circling a number below:

No pain

0	1	2	3	4	5	6	7	8	9	10
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Unbearable Pain

Instructions: 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.

SECTION 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.

SECTION 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.

SECTION 2 – PERSONAL CARE (Washing, Dressing, etc.)

- 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.

SECTION 7 – 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.

SECTION 3 – LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- Pain prevents me lifting heavy weights off the floor, but I can manage light to medium weights when conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 8 – 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 can't do any work at all.

SECTION 4 – 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).

SECTION 9 – 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 neck pain.
- I can't 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 can't drive my car at all.

SECTION 5 – 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 can't read as much as I want, because of moderate pain in my neck.
- I can hardly read at all, because of severe pain in my neck.
- I cannot read at all.

SECTION 10 – RECREATION

- I am able to engage in all my recreation activities with no neck pain.
- 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 neck pain.
- I can't do any recreational activities at all.

Patient Name: First Last	Initial Visit Date: _____
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Score: _____

Oswestry Low Back Pain Scale

Date: _____

Please rate the severity of your pain by circling a number below:

No pain

0 1 2 3 4 5 6 7 8 9 10

Unbearable Pain

Instructions: This questionnaire has been designed to give the doctor information as to how your LOW 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.

SECTION 1 – PAIN INTENSITY

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

SECTION 2 – PERSONAL CARE (Washing, Dressing, etc.)

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

SECTION 3 – LIFTING

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

SECTION 4 – WALKING

- I have no pain on walking.
- I have some pain on walking, but it does not increase with distance.
- I cannot walk more than 1 mile without increasing pain.
- I cannot walk more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5 – SITTING

- I can sit in any chair as long as I like.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.

SECTION 6 – 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 1 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 immediately.

SECTION 7 – 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 nights sleep is reduced by less than one-quarter.
- Because of pain my normal nights sleep is reduced by less than one-half.
- Because of pain my normal nights sleep is reduced by less than three-quarter.
- Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE

- My social life is normal and gives me no pain.
- My social life is normal, but it increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- 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.

SECTION 9 – TRAVELING

- I get no pain when traveling.
- I get some pain when traveling but none of my usual form of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternate forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain restricts me to short necessary journeys under ½ hour.
- Pain restricts all forms of travel.

SECTION 10 – CHANGING DEGREE OF PAIN

- My pain is rapidly getting better.
- My pain fluctuates, but is definitely getting better.
- My pain seems to be getting better, but improvement is slow.
- My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Initial Visit Date: _____

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: _____ [enter your office's full name].

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ Date: __/__/__