

## PERSONAL INJURY

To process your claim more conveniently, there are a few items this office will need from you:

- Copy of the “APPLICATION FOR PERSONAL INJURY BENEFITS.” (Usually a yellow form) If you have not reported the accident, please do so now and ask the representative for this form.
- Copy of your Insurance coverage Declaration page (this tells you what you have for insurance and the costs, etc. You receive this every annual renewal period)
- Copy of the police report if available
- Copy of the accident report if available
- Name, address and phone number of your attorney if you have consulted one.
- Other: \_\_\_\_\_

Thank you

PERSONAL INJURY QUESTIONNAIRE

NAME: \_\_\_\_\_ AUTO INSURANCE \_\_\_\_\_

ANY WITNESSES? ( ) YES ( ) NO NAMES: \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_ / \_\_\_ / \_\_\_\_\_ TIME OF DAY \_\_\_\_\_ AM/PM ROAD CONDITIONS ( ) WET ( ) DRY ( ) ICE

WHERE YOU: ( ) DRIVER ( ) PASSENGER ( ) FRONT ( ) BACK ( ) LEFT ( ) RIGHT WEARING SET BELT? ( ) YES ( ) NO

WERE YOU AWARE OF THE IMPENDING COLLISION? ( ) YES ( ) NO DID YOU BRACE FOR IMPACT? ( ) YES ( ) NO

WERE YOU LOOKING ( ) STRAIGHT AHEAD ( ) LEFT ( ) RIGHT AT THE TIME OF IMPACT?

NUMBER OF PEOPLE IN YOUR VEHICLE \_\_\_\_\_ OTHER VEHICLE \_\_\_\_\_

WHAT DIRECTION WERE YOU TRAVELLING? ( ) NORTH ( ) SOUTH ( ) EAST ( ) WEST

NAME OF STREET AND TOWN/CITY: \_\_\_\_\_

WHAT DIRECTION WAS THE OTHER VEHICLE TRAVELLING? ( ) NORTH ( ) SOUTH ( ) EAST ( ) WEST

NAME OF STREET: \_\_\_\_\_

WERE YOU STRUCK FROM BEHIND ( ) BEHIND ( ) FRONT ( ) LEFT SIDE ( ) RIGHT SIDE

DID YOU LOSE CONSCIOUSNESS? ( ) YES ( ) NO POLICE NOTIFIED? ( ) YES ( ) NO

IN YOUR OWN WORDS, PLEASE DESCRIBE THE ACCIDENT:

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DID YOU HAVE ANY PHYSICAL COMPLAINTS BEFORE THE ACCIDENT? ( ) YES ( ) NO IF YES, PLEASE DESCRIBE BELOW:

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PLEASE DESCRIBE HOW YOU FELT:  
DURING THE ACCIDENT: \_\_\_\_\_

IMMEDIATELY AFTER THE ACCIDENT: \_\_\_\_\_

LATER THAT DAY: \_\_\_\_\_

THE NEXT DAY: \_\_\_\_\_

WHAT ARE YOUR PRESENT COMPLAINTS AND SYMPTOMS: \_\_\_\_\_

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DO YOU HAVE CONGENITAL (FROM BIRTH) FACTORS, WHICH RELATE TO THE PROBLEM? ( ) YES ( ) NO

IF YES, PLEASE  
DESCRIBE: \_\_\_\_\_

DO YOU HAVE ANY PREVIOUS ILLNESSES, WHICH RELATE TO THE CASE? ( ) YES ( ) NO

IF YES, PLEASE DESCRIBE: \_\_\_\_\_

HAVE YOU EVER BEEN INVOLVED IN AN ACCIDENT BEFORE? ( ) YES ( ) NO IF YES, PLEASE DESCRIBE INCLUDING DATES AND TYPES OF ACCIDENTS, AS WELL AS INJURIES SUSTAINED:

WHERE WERE YOU TAKEN TO AFTER THE ACCIDENT? \_\_\_\_\_

HAVE YOU BEEN TREATED BY ANY OTHER DOCTOR SINCE THE ACCIDENT: ( ) YES ( ) NO IF YES, PLEASE LIST DOCTOR'S NAME AND ADDRESS: \_\_\_\_\_

WHAT TYPE OF TREATMENT DID YOU RECEIVE? \_\_\_\_\_

ARE YOUR SYMPTOMS ( ) IMPROVING ( ) GETTING WORSE ( ) THE SAME SINCE THE ACCIDENT?

HAVE YOU LOST TIME FROM WORK AS RESULT OF THE ACCIDENT? ( ) YES ( ) NO

IF YES, LAST DAY WORKED: \_\_\_\_\_ TYPE OF EMPLOYMENT: \_\_\_\_\_

DO YOU NOTICE ANY ACTIVITY RESTRICTIONS BECAUSE OF THIS INJURY? ( ) YES ( ) NO

IF YES, PLEASE DESCRIBE IN DETAIL: \_\_\_\_\_

ANY OTHER INFORMATION YOU THINK WE SHOULD KNOW?

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE**

**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 circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p><i>SECTION 1 - Pain Intensity</i></p> <p>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.</p>	<p><i>SECTION 6 - Standing</i></p> <p>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 minute without increasing pain.          F I avoid standing, because it increases the pain straight away.</p>
<p><i>SECTION 2 - Personal Care</i></p> <p>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.</p>	<p><i>SECTION 7 - Sleeping</i></p> <p>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 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.</p>
<p><i>SECTION 3 - Lifting</i></p> <p>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, eg. 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.</p>	<p><i>SECTION 8 - Social Life</i></p> <p>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, My 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.</p>
<p><i>SECTION 4 - Walking</i></p> <p>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.</p>	<p><i>SECTION 9 - Traveling</i></p> <p>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.</p>
<p><i>SECTION 5 - Sitting</i></p> <p>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.</p>	<p><i>SECTION 10 - Changing Degree of Pain</i></p> <p>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.</p>

COMMENTS: \_\_\_\_\_

SCORE: \_\_\_\_\_

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

### NECK PAIN DISABILITY INDEX QUESTIONNAIRE

**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 circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p><i>SECTION 1 - Pain Intensity</i></p> <p>A I have no pain at the moment. B The pain is very mild at the moment. C The pain is moderate at the moment. D The pain is fairly severe at the moment. E The pain is very severe at the moment. F The pain is the worst imaginable at the moment.</p>	<p><i>SECTION 6 - Concentration</i></p> <p>A I can concentrate fully when I want to with no difficulty. B I can concentrate fully when I want to with slight difficulty. C I have a fair degree of difficulty in concentrating when I want to. D I have a lot of difficulty in concentrating when I want to. E I have a great deal of difficulty in concentrating when I want to. F I cannot concentrate at all.</p>
<p><i>SECTION 2 - Personal Care (Washing, Dressing, etc.)</i></p> <p>A I can look after myself normally without causing extra pain. B I can look after myself normally, but it causes extra pain. C It is painful to look after myself and I am slow and careful. D I need some help, but manage most of my personal care. E I need help every day in most aspects of self care. F I do not get dressed, I wash with difficulty and stay in bed.</p>	<p><i>SECTION 7 - Work</i></p> <p>A I can do as much work as I want to. B I can only do my usual work, but no more. C I can do most of my usual work, but no more. D I cannot do my usual work. E I can hardly do any work at all. F I cannot do any work at all.</p>
<p><i>SECTION 3 - Lifting</i></p> <p>A I can lift heavy weights without extra pain. B I can lift heavy weights, but it gives extra pain. C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. E I can lift very light weights. F I cannot lift or carry anything at all.</p>	<p><i>SECTION 8 - Driving</i></p> <p>A I can drive my car without any neck pain. B I can drive my car as long as I want with slight pain in my neck. C I can drive my car as long as I want with moderate pain in my neck. D I cannot drive my car as long as I want because of moderate pain in my neck. E I can hardly drive at all because of severe pain in my neck. F I cannot drive my car at all.</p>
<p><i>SECTION 4 - Reading</i></p> <p>A I can read as much as I want to with no pain in my neck. B I can read as much as I want to with slight pain in my neck. C I can read as much as I want to with moderate pain in my neck. D I cannot read as much as I want because of moderate pain in my neck. E I cannot read as much as I want because of severe pain in my neck. F I cannot read at all.</p>	<p><i>SECTION 9 - Sleeping</i></p> <p>A I have no trouble sleeping. B My sleep is slightly disturbed (less than 1 hour sleepless). C My sleep is mildly disturbed (1-2 hours sleepless). D My sleep is moderately disturbed (2-3 hours sleepless). E My sleep is greatly disturbed (3-5 hours sleepless). F My sleep is completely disturbed (5-7 hours)</p>
<p><i>SECTION 5 - Headaches</i></p> <p>A I have no headaches at all. B I have slight headaches which come infrequently. C I have moderate headaches which come infrequently. D I have moderate headaches which come frequently. E I have severe headaches which come frequently. F I have headaches almost all the time.</p>	<p><i>SECTION 10 - Recreation</i></p> <p>A I am able to engage in all of my recreational activities with no neck pain at all. B I am able to engage in all of my recreational activities with some pain in my neck. C I am able to engage in most, but not all of my recreational activities because of pain in my neck. D I am able to engage in a few of my recreational activities because of pain in my neck. E I can hardly do any recreational activities because of pain in my neck. F I cannot do any recreational activities at all.</p>

COMMENTS: \_\_\_\_\_

SCORE: \_\_\_\_\_

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR  
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE**

I hereby instruct and direct the \_\_\_\_\_ Insurance Company to pay by check made out and mailed directly to:

Daniels Chiropractic Office  
33 Bedford St. Suite 10  
Lexington, MA 02420-4005

OR

If the policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

(My name)  
c/o Daniels Chiropractic Office  
33 Bedford St. Suite 10  
Lexington, MA 02420-4005

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

**A photocopy of this Assignment shall have the same force and effect as the original.**

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated at Daniels Chiropractic Office this \_\_\_\_ day of \_\_\_\_\_, 20\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print name

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

### PATIENT SYMPTOMS

On the drawing below, please indicate where you are experiencing pain by drawing the letter abbreviations on the diagrams that most accurately reflect the type of discomfort that you have been experiencing.

Numbness – N

Tingling – T

Dull Pain - D

Sharp pain – P

Burning – B

Stiffness - S

