Unionville Health Centre

2 Millstone Court, Unionville, ON, L3R 7M1 Tel: 905-475-8386 Fax: 905-534-7666

Dear Patient,

Thank you for coming to our office. We will try to make your experience as pleasant as possible in a warm and friendly environment.

Please complete **ALL** the questions in the attached sheets. (**Pages 1-15 on the bottom right hand corner**) The more complete information we have, the more accurate our conclusions will be. (**If there are any pages missing, please contact our office**)

We will report our findings back to the requesting agency, from whom you can obtain a copy.

Please let us know what we can do to make this experience more comfortable for you.

COMPREHENSIVE/CONFIDENTIAL Motor Vehicle Collision ASSESSMENT QUESTIONNAIRE

The information you provide is collected under the authority of the SABS (Government Statutory Accident Benefits Schedule). We are fully compliant with both Federal and Provincial privacy laws. All information is kept secure and is not communicated to any party for any reason except that information which you approve. We would be pleased to discuss any privacy issues with you should you have any concerns.

Please complete ALL questions carefully.

Today's Date: D______M______Y_______

Last Name: ______________________________________ First Name: _______________________________________

Address: _____________________________________ City/Prov: ___________________ Postal Code: _____________

Telephone (Res): _________________________ (Bus): ________________________ (Cell): ______________________

Gender: (circle) M / F Date of Birth: D_____M_____Y________ Marital Status: (circle) M W S D

Health Card No. ________________________ Version Code ______ e-mail: __________________________________

Referred by: ______________________________________ (e.g., name of friend / family / doctor / sign / yellow pages)

DOCTOR INFORMATION:

Family Doctor:________________________________ Telephone:____________________ Fax:_____________________

Address: _____________________________________ City/Prov: ___________________ Postal Code: _____________

INSURANCE INFORMATION:

Motor Vehicle Insurance:

Name of Insurance Company: ____

Address: _____________________________________ City/Prov: ___________________ Postal Code: _____________

____

Claims Adjuster:_________________________________ Policy Holder:____

Telephone: ________________ Fax: ________________ Policy#: ___________________ Claim# ___________________

Health Insurance Information:

Do you and/or your partner have an Extended Health Plan? (check one)

[ ] Yes, I do [ ] Yes, my partner does [ ] Yes, we both do [ ] No, I do not have coverage

Check coverage: ( ) Chiro ( ) Orthotics ( ) Physio ( ) Psychology ( ) Acupuncture ( ) Massage

Name of Insured: ______________________________ Insurance Co.:____

Address: _______________________________________ City/Prov: ____________________ Postal Code: ______________

Telephone: __________________ Fax: __________________ Policy#: ____________________ Group#:__________________

LAWYER INFORMATION:

Lawyer Name:__________________________________Name of Law Firm:_______________________________________

Address: _______________________________________ City/Prov: ____________________ Postal Code: ______________

Telephone: ____ Fax: ____

==

1. What is your greatest concern at this time? ____

2. Is this a re-occurrence ? ( ) Yes ( ) No

3. Do you feel your problem is (circle one) a) temporary or b) permanent

4. On a scale of 0 to 100, where 100 is normal, **how much have you recovered SYMPTOMATICALLY (how you feel)** since the onset of the problem:
   0----------10----------20----------30----------40----------50----------60----------70----------80----------90---------100
   no improvement / slight improvement / moderate / marked improvement / almost no symptoms / fully recovered

5. On a scale of 0 to 100, where 100 is normal, **how much have you recovered FUNCTIONALLY (what you can do)** since the onset of the problem:
   0----------10----------20----------30----------40----------50----------60----------70----------80----------90---------100
   no improvement / slight improvement / moderate / marked improvement / almost no symptoms / fully recovered

Name:______________________________ Date:______/______/______

PAIN DIAGRAM:

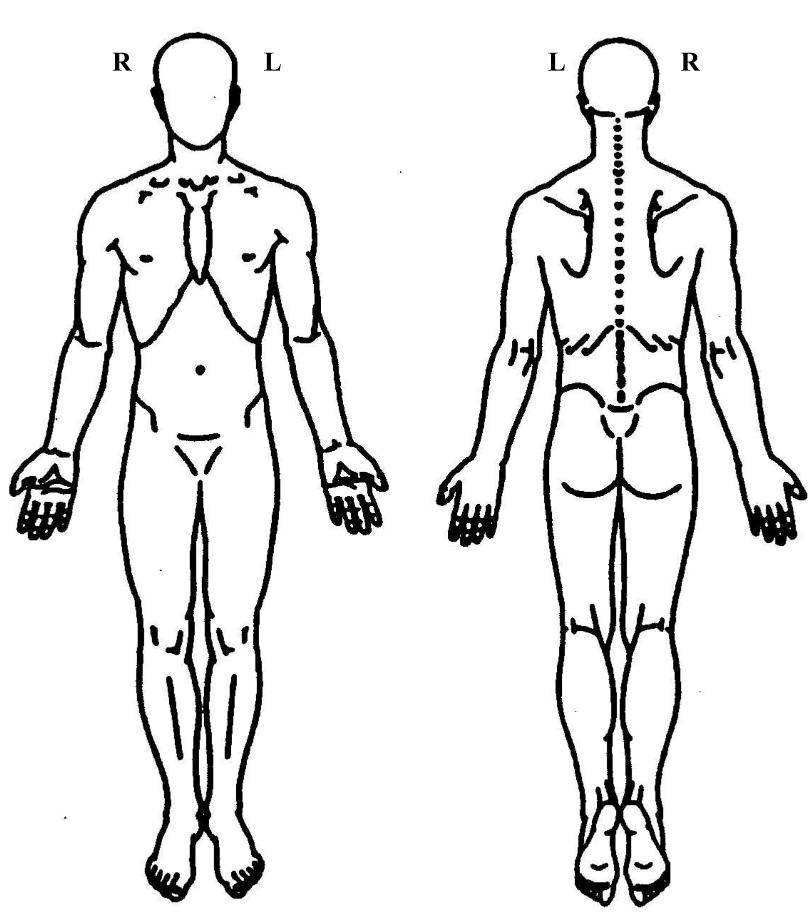
Check if you have any of the following pain symptoms:

□ Pain	□ Numbness	□ Weakness	□ Electric Shock
□ Pins & Needles	□ Itching	□ Tingling	

On the diagram, draw where you have these symptoms….use the following symbols

Pain PPP   Numbness OOO   Weakness WWW   Electric Shock SSS

Itching III   Pins & Needles/Tingling ZZZ



Write any comments or concerns that you would like the doctor to focus on: ______________________________
____
____
____

5. Please **indicate your present level of pain/severity for each of the body areas listed using this Symptom Rating Scale below**: **(Mark a number in each region-0 if no pain problems X if no complaint in the region)**
   1---------------2---------------3---------------4---------------5---------------6---------------7---------------8---------------9---------------10
   mild pain moderate pain marked pain severe pain excruciating pain

   Symptoms description: Feel free to use these terms to describe your symptoms in each section, or add your own (eg. Pain, sharp, dull, achy, numbness, tightening, stiffness, weakness, burning, stabbing, pins & needles, tingling)

   a. **Headaches**: **(Pain level 1-10)** [ ]

   Describe your symptoms____
   Location ______________________ Aggravating factors ______________________
   Frequency ______________________ Relieving factors ______________________
   Duration ______________________

   b. **Face (TMJ-jaw): (Pain level 1-10)** [ ]

   Describe your symptoms____
   Location ______________________ Aggravating factors ______________________
   Frequency ______________________ Relieving factors ______________________
   Duration ______________________

   c. **Neck: (Pain level 1-10)** [ ]

   Describe your symptoms____
   Location ______________________ Aggravating factors ______________________
   Frequency ______________________ Relieving factors ______________________
   Duration ______________________

   d. **Upper Trapezii (Areas between neck and shoulder joint): (Pain level 1-10)** [ ]

   Describe your symptoms____
   Location ______________________ Aggravating factors ______________________
   Frequency ______________________ Relieving factors ______________________
   Duration ______________________

   e. **Shoulder Blades (“Wingbone”/Scapula): (Pain level 1-10)** [ ]

   Describe your symptoms____
   Location ______________________ Aggravating factors ______________________
   Frequency ______________________ Relieving factors ______________________
   Duration ______________________

   f. **Shoulders and Upper Arms: (Pain level 1-10)** [ ]

   Describe your symptoms____
   Location ______________________ Aggravating factors ______________________
   Frequency ______________________ Relieving factors ______________________
   Duration ______________________

   g. **Elbows: (Pain level 1-10)** [ ]

   Describe your symptoms____
   Location ______________________ Aggravating factors ______________________
   Frequency ______________________ Relieving factors ______________________
   Duration ______________________

h. **Forearms and/or Wrists (Circle either or both where appropriate): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ______________________________ Aggravating factors ______________________________
Frequency _____________________________ Relieving factors ________________________________
Duration ______________________________

i. **Hands and Fingers (Circle either or both where appropriate): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ______________________________ Aggravating factors ______________________________
Frequency _____________________________ Relieving factors ________________________________
Duration ______________________________

j. **Upper Back (Thoracic): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ______________________________ Aggravating factors ______________________________
Frequency _____________________________ Relieving factors ________________________________
Duration ______________________________

k. **Lower Back (Lumbar): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ______________________________ Aggravating factors ______________________________
Frequency _____________________________ Relieving factors ________________________________
Duration ______________________________

l. **Hips/Pelvis/S.I./Groin (Circle all affected areas): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ______________________________ Aggravating factors ______________________________
Frequency _____________________________ Relieving factors ________________________________
Duration ______________________________

m. **Buttocks: (Pain level 1-10)** [ ]

Describe your symptoms____
Location ______________________________ Aggravating factors ______________________________
Frequency _____________________________ Relieving factors ________________________________
Duration ______________________________

n. **Thighs and/or Knees (Circle either or both where appropriate): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ______________________________ Aggravating factors ______________________________
Frequency _____________________________ Relieving factors ________________________________
Duration ______________________________

o. **Lower Leg and/or Ankles (Circle either or both where appropriate): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ______________________________ Aggravating factors ______________________________
Frequency _____________________________ Relieving factors ________________________________
Duration ______________________________

p. **Feet and Toes (Circle either or both where appropriate): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ______________________________ Aggravating factors ______________________________
Frequency _____________________________ Relieving factors ________________________________
Duration ______________________________

q. **Sleep:** [ ] well [ ] poorly [ ] Difficult falling asleep [ ] Wake up ________/per night ;
Sleep on : side/back/front

How long does it take to fall asleep? __________ minutes How much sleep do you get? _________ hours

On average how many hours do you: Spend in bed? __________ Spend sleeping? __________
Previous Sleep Study : [ ] Yes [ ]No

r. **Psychological/ Neurological :** Increased challenges or changes with any of the following (check all that apply):

[ ] Anxiety [ ] Concentration [ ] Depression [ ] Dizziness [ ] Driving [ ] Irritability [ ] Memory [ ] Stress
[ ] Speech [ ] Hand writing [ ] Balance [ ] Dropping things

Other symptoms: ____
____

Please indicate specifically any **current** treatments that you are receiving with a number indicating the frequency in the **Times/wk** box (Place a **P** to the right of the **Times/wk** box if the treatment was done in the PAST (but not currently):

	Dr/Therapist Name	Times/wk		Helpful (check)		Dr/Therapist Name	Times/wk		Helpful (check)
Acupuncture	__________	[ ]	___	[ ]	NET	__________	[ ]	___	[ ]
Aqua therapy	__________	[ ]	___	[ ]	Nutrition	__________	[ ]	___	[ ]
Chiropractic	__________	[ ]	___	[ ]	Physiotherapy	__________	[ ]	___	[ ]
Exercise therapy	__________	[ ]	___	[ ]	Psychotherapy	__________	[ ]	___	[ ]
Graston	__________	[ ]	___	[ ]	TMJ (jaw therapy)	__________	[ ]	___	[ ]
Massage therapy	__________	[ ]	___	[ ]	Other	__________	[ ]	___	[ ]
Other	__________	[ ]	___	[ ]	Other	__________	[ ]	___	[ ]

6. **What activities are you having limitations with or do you find aggravating? (circle):**

1) Accounting **2)** Balance **3)** Bending **4)** Computer/Keyboard Use **5)** Dressing **6)** Eating **7)** Fatigue
8) Fine Hand Activities **9)** Food Preparation **10)** Gripping **11)** Housework **12)** Hygiene **13)** Kneeling **14)** Lifting
15) Pulling **16)** Pushing **17)** Reaching **18)** Reading **19)** Recreation **20)** Self-Care **21)** Sexual Function
22) Shopping **23)** Sitting **24)** Sleeping **25)** Stairs **26)** Standing **27)** Stooping **28)** Transportation/Travel
29) Walking **30)** Others ____

7. **Which of the following provides some relief or comfort? (circle):**

Acupuncture / aqua therapy / changing position / chiropractic / electrical modalities (IFC/TENS) / exercise / heat / ice / lying down / massage therapy / osteopathy / physiotherapy / rest / stretching / Other__________________________

8. **Surgery (type and year): Circle any that apply and provide year in space**

Appendix	______	Breast	______	Gall bladder	______	Hernia	______	Tonsillectomy	______
Hysterectomy	______	Prostate	______	Wisdom Teeth	______	Intestinal	______	Cardiac	______
Bone	______	Joint	______	Other:	______________________	______			

9. For any problems experienced by you (use S-self) and/or anyone in your family (use F-family), please indicate as follows: --

AIDS	[ ]	Fainting	[ ]	Memory problems	[ ]
Arthritis	[ ]	Faulty posture	[ ]	Mental disorders	[ ]
Asthma	[ ]	Foot Trouble	[ ]	Nerve problems	[ ]
Bladder, kidney, bowel	[ ]	Heart disease	[ ]	Neurological disease	[ ]
Cancer of ____________	[ ]	Hernia	[ ]	Obesity	[ ]
Cholesterol	[ ]	HIV (AIDS) exposure	[ ]	Osteoporosis	[ ]
Diabetes	[ ]	High blood pressure	[ ]	Seizures	[ ]
Digestive problems	[ ]	Hypertension	[ ]	Stroke	[ ]
Drug/Alcohol abuse	[ ]	Liver disease	[ ]	Thyroid disease	[ ]
Eyes, ear, nose, throat	[ ]	Lung problems/asthma	[ ]	Other ______________	[ ]

10. **Females only:**
a) Menstrual [ ] PMS [ ] Are you pregnant? YES NO

b) Have there been any changes to your menstrual cycle since your motor vehicle collision? If yes, please explain:
____
____

11. Are you adopted? (check one): ☐ Yes ☐ No

12. Lifestyle:---

Smoking: [ ] never [ ] quit ______ years(s) ago [ ] smoke ______ pack/day now
Alcohol: [ ] never [ ] seldom 1/mth [ ] regular 5/wk [ ] daily ______oz. daily
Caffeine: [ ] never [ ] occasional coffee/tea [ ] 1-3 cups daily [ ] over 5 cups/daily
Diet: [ ] regular food [ ] vegetarian [ ] recent weight gain/loss (see below)

13. What is your height: ______________________________ Weight: _______________

14. Allergies: [ ] None [ ] Yes (List Below):
____

15. List any serious accidents, falls, hospitalization, or loss of consciousness (type and year): ________________________
____

16. Fractures: Which bones _________________________________What age:___________________________________

17. List previous medications, prior to accident: ____
____

18. List present medications: provide name, amount (Dosage), how often (Frequency) and for how long they were/have been taken (Duration) in the chart below: If you need additional space, please list them on a separate page.

Name of medication	Dosage	Frequency	Duration	Reason for taking medication

19. List present vitamins or supplements: provide name, amount (Dosage), how often (Frequency) and for how long they were/have been taken (Duration) in the chart below: If you need additional space, please list them on a separate page.

Name of supplement	Dosage	Frequency	Duration	Reason for taking supplement

20. When did you last feel 100% healthy? ____________________ Is this one of your goals? (circle one) **YES** **NO**

21. **What Are your hobbies? Please check mark**

[ ] Music [ ] Food [ ]Travel [ ] Reading/Writing [ ] Health and Fitness
[ ] Pets [ ] Socializing [ ] Technology/computers [ ] Video Games
[ ] Watching sports [ ] Arts and Crafts [ ] Gardening [ ] Playing Sports [ ] Photography

Other:____

DETAILED Motor Vehicle Collision QUESTIONNAIRE
Mechanism of Injury Details

Please examine and review each question carefully. You **must check** at least one box for each question. If you are unsure of the answer, check the "Decline to Answer/DTA" box.

Date of Collision: ______________________________ Time: ____

21. Where did the collision happen? ____

Indicate on this diagram what happened (Please modify as necessary)

Use one of these outlines to sketch the scene of your collision, including street or highway names or numbers.

- Number each vehicle and show direction of travel by arrows
- Use solid line to show path **before collision**____________, use dotted line **after collision**_ _ _ _ _ _ _ _.
- Show pedestrian by **X.**
- Show railroad by ┼┼┼┼┼┼┼┼┼┼┼
- Show distance and direction to landmarks, identify landmarks by name and number.
- Indicate north with an arrow, e.g. N ◄──┼

Collision Details
Describe the collision in your own words:

____
____
____
____

22. Road Conditions: ☐ Dry ☐ Wet ☐ Ice ☐ Snow ☐ Other ____________________________ ☐ Decline to Answer

23. a. Vehicle you were in:
Vehicle Model ____________________ Vehicle Year __________ Damage: $________ -----☐ Decline to Answer

b. Other vehicle:
Vehicle Model ____________________ Vehicle Year __________ Damage: $________ --- ☐ Decline to Answer

Were any other passengers or persons involved? Please list names and extent of the injuries, if known:

____
____
____

24. As a result of the collision were traffic citations issued to you? ☐Yes ☐ No -------------------- ☐ Decline to Answer

25. Did the collision occur in the course of your work? ☐Yes ☐ No ------------------- ☐ Decline to Answer

26.Were you aware of the oncoming collision? --- ☐ Decline to Answer
☐ Yes ☐ No

27. What was your position in the car? --- ☐ Decline to Answer
☐ Driver ☐ Front Passenger ☐ Right Rear Passenger ☐ Left Rear Passenger ☐ N/A- Pedestrian

28. Did your vehicle strike another vehicle? -- ☐ Decline to Answer
☐ Yes ☐ No

29. Was your car struck by another vehicle? --- ☐ Decline to Answer
☐ Yes ☐ No

30. Was the impact from: --- ☐ Decline to Answer
☐ The Front ☐ Right side ☐ Left Side ☐ The Rear

31. At the time of the impact were you: -- ☐ Decline to Answer
☐ Looking straight ahead ☐ Looking right ☐ Looking left

32. Were: Both hands on the steering wheel? ☐ Yes ☐ No -- ☐ Decline to Answer
Foot on the brake? ☐ Yes ☐ No
Braced for impact? ☐ Yes ☐ No

33. Where were you in the car after the collision?-- ☐ Decline to Answer
____

34. Was your seat belt fastened? --- ☐ Decline to Answer
☐ Yes, lap and shoulder ☐ Yes, shoulder only ☐ Yes, lap only
☐ No ☐ Not applicable ☐ Do not know

35. Was there a headrest on your seat? -- ☐ Decline to Answer
☐ No ☐ Yes, fixed ☐ Yes, adjustable ☐ Yes, type unknown ☐ Do not know ☐ Not applicable

36. Is your car equipped with airbags? -- ☐ Decline to Answer
☐ Yes ☐ No

37. Did your airbag inflate? --- ☐ Decline to Answer
☐ Yes ☐ No

38. Did you strike anything in the vehicle at the time of the impact? --- ☐ Decline to Answer
☐ Yes ☐ No

39. Which part of the vehicle did you strike? -- ☐ Decline to Answer
☐ Not Applicable ☐Steering Wheel ☐ Dashboard ☐ Windshield ☐ Side Window ☐ Arm Rests ☐ Side Door

40. Which part of your body struck the vehicle? -- ☐ Decline to Answer
☐ Not Applicable ☐ Chest ☐ Chin ☐ Knee ☐ Shoulder ☐ Hand ☐ Head ☐ Other _______________

41. Were you rendered: -- ☐ Decline to Answer
☐ Unconscious (if yes, how long) ____
☐ Cut or bleeding (describe) ____
☐ Neither

42. Indicate any pain / abnormal sensations you experienced immediately following the collision: ----- ☐ Decline to Answer

☐ Felt no immediate pain
☐ Pain began immediately after the collision
☐ Pain began several hours after collision
☐ Semi-conscious state
☐ Saw stars
☐ Other ___________________________

☐ Head pain (headache
☐ Neck pain – (Rt/Lt)
☐ Mid back pain – (Rt/Lt)
☐ Lower back pain – (Rt/Lt)
☐ Upper extremity pain -- (Rt/Lt)
☐ Lower extremity pain (Rt/Lt)

43. Indicate who attended the collision scene: --- ☐ Decline to Answer

☐ police ☐ ambulance ☐ fire ☐ no official personnel present

44. Indicate the action you took immediately following the collision: --- ☐ Decline to Answer

☐ Went home and took it easy
☐ Went home later (drove/was driven) to ____________ hospital
☐ Went about normal business
☐ Doctored myself thinking pain would go away (OTC products)
☐ Went to physician
☐ Was taken to the hospital by ambulance
☐ Went to collision reporting centre
☐ Attended Urgent Care/Walk-In Clinic
☐ Went home and (shortly after/later that night/following morning) experienced (neck/mid back/low back) pain

45. Indicate method of delivery to hospital: (if applicable) --- ☐ Decline to Answer

☐ Ambulance ☐ Drove myself ☐ Driven by spouse/relative/friend/employer

Name of Hospital: _____________________________ Address: ____

Were you seen in the emergency room? Yes ☐ No ☐

Were you admitted to the hospital? Yes ☐ No ☐

Length of stay? ___________________________________

Name (if known) of admitting physician:____

46. Indicate any procedures performed at the hospital (including emergency room): ------------------------ ☐ Decline to Answer

☐ Examination ☐ X-rays ☐ Prescription ☐ Injection ☐ Complete bed rest ☐ Stitches
☐ Physiotherapy ☐ Cervical collar ☐ Wounds Dressed ☐ MRI/CT ☐ Surgery ☐ Other _______

47. Following your release from the hospital were you advised to -- ☐ Decline to Answer

☐ Return home and take it easy ☐ Return home and go to bed ☐ Return to work
☐ Return home and return to the emergency room after ________hours/days

48. When did you first consult a health care provider, after leaving the hospital?----------------------------- ☐ Decline to Answer

☐ Not applicable ☐ Same day ☐ Following day ☐ Within a few days, how many _______
☐ Who was it? (Family doctor, chiropractor, etc) ____

49. List types and names of ALL health care providers you have seen since leaving the hospital or since the accident, or since the accident? --- ☐ Decline to Answer

☐ Acupuncturist________________________________
☐ Physiatrist ______________________________
☐ Chiropractor ________________________________
☐ Psychiatrist ______________________________
☐ GP/Family Physician __________________________
☐ Physiotherapist ___________________________
☐ Massage Therapist ___________________________
☐ Psychologist ______________________________
☐ Neurologist ________________________________
☐ Walk-in Clinic _____________________________
☐ Orthopaedic Surgeon _________________________
☐ Other ___________________________________

50. What interventions have you had done? Indicate practitioner/clinic name: ---------------------------------- ☐ Decline to Answer

☐ Acupuncture________________________________ ☐ Collar/Support (belt/brace)______________________
☐ Drugs____________________________________ ☐ Electro/Physiotherapy (eg. IFC, Tens, US)__________
☐ Examination________________________________ ☐ Exercise____
☐ Injections _________________________________ ☐ Manipulation only______________________________
☐ Psychotherapy ____________________________ ☐ Traction____
☐ Other____

Exercise

51. **<u>Pre</u> – Motor Vehicle Collision (MVC)** Activity Level (times per week exercising) ---------------------- ☐ Decline to Answer

☐ Sedentary (0) ☐ Slightly Active (1-2) ☐ Moderately Active (3-4) ☐ Very Active (5-7)

52. Gym Membership --- ☐ Decline to Answer

Pre-MVC ☐ Yes ☐ No

Currently ☐ Yes ☐ No ☐ On Hold

If you have **<u>STOPPED</u>** attending, indicate reason: ____

53. What types of exercises were you performing **<u>BEFORE</u>** the MVC? --- ☐ Decline to Answer
(**write down the number of times per week**)

Cardio _____ Stretching _____ Weights/Machines _____ Elastic Bands _____ Stability Ball _____ Aqua _____

Other: _________________________ Other:____________________ _____ Other:____________________ _____

54. **<u>CURRENT</u>** Activity Level (times per week exercising) --- ☐ Decline to Answer

☐ Sedentary (0) ☐ Slightly Active (1-2) ☐ Moderately Active (3-4) ☐ Very Active (5-7)

55. What types of exercises are you **<u>CURRENTLY</u>** performing? --- ☐ Decline to Answer
(write down the number of times per week)

Cardio _____ Stretching _____ Weights/Machines _____ Elastic Bands _____ Stability Ball _____ Aqua _____

Other: _________________________ Other:____________________ _____ Other:____________________ _____

56. What do you think you require to be able to perform exercises independently at Pre-MVC levels? ---☐ Decline to Answer

☐ Instruction ☐ Motivation ☐ Supervision ☐ Other: ____

Tests: (Please ensure reports are available if possible)

57. Were you referred to any other physician or sent for any special diagnostic tests or examinations?--☐ Decline to Answer
Yes ☐ No ☐ If yes, list type and name ☐ _______________________ ☐ _______________________
☐ _______________________ ☐ _______________________

☐ MRI ☐ CT ☐ EMG ☐ Nerve Conduction Exam ☐ Sleep Test ☐ Thermography ☐ X-ray

☐ Other:____

58. How long have you been under the care of your current family physician? -------------------------------☐ Decline to Answer

Name: ______________________________ Number of years: ________ Seen prior to the collision? Yes☐ No ☐

59. Are you still under the same doctor's care? -- ☐ Decline to Answer

Yes ☐ If yes, indicate the frequency of your visits to the doctor: ____

No ☐ If no, when were you discharged? ____

60.If you were sent for an independent medical examination, name of physician/clinic: ------------------- ☐ Decline to Answer

____

____

61. Other pertinent information you wish to share: -- ☐ Decline to Answer

____

____

Pre-Injury Status and Secondary Conditions:

62. Have you previously been treated for any neck or back problems? --------------------------------------- ☐ Decline to Answer

Why and what year: ____

Previous Collisions:

63. Have you been involved in any previous motor vehicle collisions or injuries of any kind? ---------- ☐ Decline to Answer

☐ Yes ☐ No If yes, list dates and details:____

____

64. Have you previously been treated by a physiotherapist or chiropractor at **any** time? --------------- ☐ Decline to Answer

Please explain: ____

____

65. Past conditions or surgical history that could affect present condition: ---------------------------------- ☐ Decline to Answer

____

____

66. Did you enjoy good health prior to this collision? -- ☐ Decline to Answer

☐ Yes ☐ No (Explain): ____

____

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how low back pain has affected your ability to manage everyday life. **Please answer every section**. We realize you may consider that two of the statements in any one section relate to you, but please just **mark only ONE box in that section** 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
- ☐ 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 and dressing without help.

SECTION 3 – LIFTING
- ☐ I can lift heavy weight without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ 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 but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the 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 one km. Without increasing pain.
- ☐ I cannot walk more than ½ km without increasing pain.
- ☐ I cannot walk more than ¼ km 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 only sit in my favourite chair as long as I like.
- ☐ Pain prevents me from sitting more than an hour.
- ☐ Pain prevents me from sitting more than a ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

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 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 straight away.

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 night's sleep is reduced by less than ¼.
- ☐ Because of pain my normal night's sleep is reduced by less than ½.
- ☐ Because of pain my normal night's sleep is reduced by less than ¾.
- ☐ 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 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 – TRAVELLING
- ☐ I get no pain while travelling.
- ☐ I get some pain while travelling, but none of my usual forms of travel make it worse.
- ☐ I get extra pain while travelling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain whilst travelling 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.

SECTION 10 – CHANGING DEGREE OF PAIN
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely 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.

____________ X 2 = ___________%

Pain Severity Scale:
Rate the Severity of your pain by checking one box on the following scale where 0 is NO PAIN and 10 is Excruciating Pain

0	1	2	3	4	5	6	7	8	9	10

NECK PAIN AND DISABILITY INDEX (VERNON-MIOR)

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

SECTION 3 – 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, 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.

SECTION 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 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 5 – 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 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 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 can't do any work at all.

SECTION 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 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 9 – SLEEPING
- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1 to 2 hours sleepless).
- ☐ My sleep is moderately disturbed (2 to 3 hours sleepless).
- ☐ My sleep is greatly disturbed (3 to 5 hours sleepless).
- ☐ My sleep is completely disturbed (5 to 7 hours sleepless).

SECTION 10 – 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 pain in my neck.
- ☐ 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 a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

____________ X 2 = ___________%

Pain Severity Scale:
Rate the Severity of your pain by checking one box on the following scale where 0 is NO PAIN and 10 is Excruciating Pain

0	1	2	3	4	5	6	7	8	9	10