VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Today's Date:_____

Patient Name_____

Date of Accident_____Time of Accident_____ ☐ A.M. ☐ P.M.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersecting road/street_____

Driving conditions were:

☐ Dry ☐ Wet ☐ Icy ☐ Other_____

Which direction were you headed (NSEW)?_____

Speed you were traveling?_____MPH

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Is vehicle airbag-equipped? ☐ Yes ☐ No

If yes, did they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest? ☐ Low ☐ Middle ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain:_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain _____

_____

Was impact from:

☐ Front, ☐ Rear, ☐ Left, ☐ Right, ☐ Other___

At the time of impact were you looking:

☐ Straight ahead ☐ To the left ☐ Up ☐ To the right ☐ Down

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was no the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE

(if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom? _____

PATIENT:

INSURANCE INFORMATION

Name of person at fault for the accident:_____ Insurance Co._____

Ins. Co. Phone:_____ Adjuster:_____ Claim #:_____

Name of owner of vehicle you were in:_____ Insurance Co._____

Ins. Co. Phone:_____ Adjuster:_____ Claim #:_____

Attorney name and address:_____ Phone #:_____

TREATMENT

Did you go to the hospital? ☐ YES ☐ NO

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital:_____ Name of doctor:_____

Diagnosis:_____

_____

Treatment received:_____

_____

X-rays taken:_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ YES ☐ NO How many work days have you missed?_____

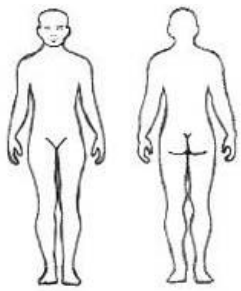
Prior to the injury were you able to work on an equal basis with others your age? ☐ YES ☐ NO

If you have had any of the following symptoms since your injury, please (√) check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiffness
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ YES ☐ NO ☐ UNKNOWN

Mark an "X" on the picture where you continue to have pain, numbness, or tingling → →



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

I certify that the above information is correct to the best of my knowledge.

Patient Signature_____ Date:_____

Signature of Parent/legal guardian (if minor):_____ Date:_____

Neck Index

Patient Name_____ ***Date***_____

*This questionnaire will give your provider information about how your **NECK** condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

Pain Intensity

⓪ I have no pain at the moment.

① The pain is very mild at the moment.

② The pain comes and goes and is moderate.

③ The pain is fairly severe at the moment.

④ The pain is very severe at the moment.

⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.

① My sleep is slightly disturbed (less than 1 hour sleepless).

② My sleep is mildly disturbed (1-2 hours sleepless).

③ My sleep is moderately disturbed (2-3 hours sleepless).

④ My sleep is greatly disturbed (3-5 hours sleepless).

⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.

① I can read as much as I want with slight neck pain.

② I can read as much as I want with moderate neck pain.

③ I cannot read as much as I want because of moderate neck pain.

④ I can hardly read at all because of severe neck pain.

⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.

① I can concentrate fully when I want with slight difficulty.

② I have a fair degree of difficulty concentrating when I want.

③ I have a lot of difficulty concentrating when I want.

④ I have a great deal of difficulty concentrating when I want.

⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.

① I can only do my usual work but no more.

② I can only do most of my usual work but no more.

③ I cannot do any work at all.

④ I cannot do my usual work.

⑤ I can hardly do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.

① I can look after myself normally but it causes extra pain.

② It is painful to look after myself and I am slow and careful.

③ I need some help but I manage most of my personal care.

④ I need help every day in most aspects of self care.

⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.

① I can lift heavy weights but it causes extra pain.

② I can only lift very light weights.

③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).

④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.

⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.

① I can drive my car as long as I want with slight neck pain.

② I can drive my car as long as I want with moderate neck pain.

③ I cannot drive my car at all because of neck pain.

④ I cannot drive my car as long as I want because of moderate neck pain.

⑤ I can hardly drive at all because of severe neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.

① I am able to engage in all my usual recreation activities with some neck pain.

② I cannot do any recreation activities at all.

③ I am only able to engage in a few of my usual recreation activities because of neck pain.

④ I can hardly do any recreation activities because of neck pain.

⑤ I am able to engage in most but not all my usual recreation activities because of neck pain.

Headaches

⓪ I have no headaches at all.

① I have slight headaches which come infrequently.

② I have moderate headaches which come infrequently.

③ I have headaches almost all the time.

④ I have moderate headaches which come frequently.

⑤ I have severe headaches which come frequently.

Office Use Only:

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

NECK INDEX SCORE = _____

Middle/Lower Back Index

Patient Name_____ ***Date***_____

*This questionnaire will give your provider information about how your **MIDDLE/LOWER BACK** condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

Pain Intensity

⓪ The pain comes and goes and is very mild

① The pain is mild and does not vary much

② The pain comes and goes and is moderate

③ The pain is moderate and does not vary much

④ The pain comes and goes and is very severe

⑤ The pain is very severe and does not vary much

Sleeping

⓪ I get no pain in bed

① I get pain in bed but it does not prevent me from sleeping well

② Because of pain my normal sleep is reduced by < 25%

③ Because of pain my normal sleep is reduced by < 50%

④ Because of pain my normal sleep is reduced by < 75%

⑤ Pain prevents me from sleeping at all

Sitting

⓪ I can sit in any chair as long as I like

① I can only sit in my favorite chair as long as I like

② Pain prevents me from sitting more than 1 hour

③ Pain prevents me from sitting more than ½ hour

④ Pain prevents me from sitting more than 10 minutes

⑤ I avoid sitting because it increases pain immediately

Standing

⓪ I can stand as long as I want without pain

① I have some pain while standing but it does not increase with time

② I cannot stand for longer than 1 hour without increasing pain

③ I cannot stand for longer than ½ hour without increasing pain

④ I cannot stand for longer than 10 minutes without increasing pain

⑤ I avoid standing because it increases pain immediately

Walking

⓪ I have no pain while walking

① I have some pain while walking but it doesn't increase with distance

② I cannot walk more than 1 mile without increasing pain

③ I cannot walk more than ½ mile without increasing pain

④ I cannot walk more than ¼ mile without increasing pain

⑤ I cannot walk at all without increasing pain

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain

① I do not normally change my way of washing or dressing even though it causes some pain

② Washing and dressing increases the pain but I manage not to change my way of doing it

③ Washing and dressing increases the pain and I find it necessary to change my way of doing it

④ Because of the pain I am unable to do some washing and dressing without help

⑤ Because of the pain I am unable to do any washing or dressing without help

Lifting

⓪ I can lift heavy weights without extra pain.

① I can lift heavy weights but it causes extra pain.

② Pain prevents me from lifting heavy weights off the floor

③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).

④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.

⑤ I can only lift very light weights

Traveling

⓪ I get no pain while traveling

① I get some pain while traveling but none of my usual forms of travel make it worse

② I get extra pain while traveling but it does not cause me to seek alternate forms of travel

③ I get extra pain while traveling which causes me to seek alternate forms of travel

④ Pain restricts all forms of travel except that done while lying down

⑤ Pain restricts all forms of travel

Social Life

⓪ My social life is normal and gives me no extra pain

① My social life is normal but increases the degree of pain

② Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.)

③ Pain has restricted my social life and I do not go out very often

④ Pain has restricted my social life to my home

⑤ I have hardly any social life because of the pain

Changing Degree of Pain

⓪ My pain is rapidly getting better

① My pain fluctuates but overall is definitely getting better

② My pain seems to be getting better but improvement is slow

③ My pain is neither getting better or worse

④ My pain is gradually worsening

⑤ My pain is rapidly worsening

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BACK INDEX SCORE = _____