MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

PATIENT INFORMATION

Name: _____ *DOB*: _____ *Today's date*: _____

Date of accident: _____ *Time of accident*: _____ AM / PM

What are your present complaints / symptoms as a result of the accident? _____

_____

_____

Please check symptoms you have noticed since the accident:

___ neck pain	___ loss of balance	___ upper back pain	___ cold sweats
___ stiffness in neck	___ loss of memory	___ lower back pain	___ nervousness / anxiety
___ headache	___ face flushed	___ pins & needles in legs	___ irritability
___ dizziness	___ pins & needles in arms	___ numbness in legs / feet	___ fatigue
___ sensitivity to light	___ numbness in hand / arm	___ pain into legs / feet	___ fainting
___ head feels "heavy"	___ pain into arms / hand	___ cold feet	___ depression
___ loss of smell	___ cold hands	___ constipation / diarrhea	___ sleep problems
___ loss of taste	___ tension	___ chest pain	___ fever
___ buzzing in ears	___ ringing in ears	___ shortness of breath	___ upset stomach

Did you have any physical complaints before this accident? Yes No

Please describe: _____

_____

Occupation: _____

Have you missed time from work? Yes No *If yes, dates missed*: From _____ To _____

ACCIDENT DETAILS

Driver of car you were in? _____ *Owner of car?* _____

Where in car were you seated?

Front – Driver's Side Front – Passenger Side

Rear – Driver's Side Rear - Middle Rear – Passenger Side

In your own words, please describe the accident: _____

_____

_____

_____

Where was your car struck?

Head-On Collision	Rear Impact	Non-Collision
Broad-Side Collision on Right	Broad-Side Collision on Left	Other: _____

Please explain damage done to the car you were in: _____

_____

Visibility at time of accident: Poor Fair Good Other: _____

Road conditions at time of accident: Icy Rainy Wet Clear Dark Other: _____

What was your head / body position at the time of impact?

Head Straight Forward	Head Turned Left / Right	Head Looking Back
Body Straight in Sitting Position	Body Turned Left / Right	Other: _____

At the time of the accident, what parts of your head / body hit what parts on the inside of the car?

_____

_____

Did you see the accident coming?	Yes	No	Not Sure
Did you brace for impact?	Yes	No	Not Sure
Were you wearing a seatbelt?	Yes	No	Not Sure
Does the car have headrests?	Yes	No	Not Sure
Was your car braking?	Yes	No	Not Sure
Was your car moving at the time of the accident?	Yes	No	Not Sure

If yes, how fast was your car moving? _____

How fast would you estimate the other vehicle was moving? _____

Please describe how you felt:

- *During the accident –* _____
- *Immediately after the accident –* _____
- *Later that day –* _____
- *The next day –* _____

Were you given medical attention after the accident? Yes No

If yes, how did you get there? Ambulance Police Drove Own Car Someone Else Drove Me

Other: _____

Name of medical facility: _____ *Date of medical examination*: _____

Name of doctor seen: _____ *Was imaging / testing performed?* Yes No

If yes, what kind? X-ray CT MRI Blood Test

Other: _____

Did you receive any form of treatment? Yes No

If yes, what kind? Medication Brace Collar Other: _____

If yes, did the treatment benefit you? Yes No

How so? _____

Have you seen anyone else for this condition? Yes No

Name of person(s) seen: _____

Do you have an attorney in regards to this claim? Yes No

Attorney's name: _____ *Law firm*: _____

Address: _____ *Phone*: _____

ACTIVITIES OF DAILY LIVING ASSESSMENT

DIRECTIONS: Please check the ***ONE*** item in each section which most closely applies to you.

PAIN INTENSITY

___ I can tolerate the pain I have without painkillers.
___ The pain is bad, but I manage without painkillers.
___ Painkillers give complete relief from pain.
___ Painkillers give moderate relief from pain.
___ Paikillers give very little relief from pain.
___ Painkillers give no relief from pain and I do not use them.

PERSONAL CARE

___ I can look after myself normally without causing extra pain.
___ I can look after myself normally, but it results in extra pain.
___ It is painful to look after myself so I am slow and careful.
___ I need some help everyday in most aspects of self-care.
___ I do not get dressed, I wash with difficulty, and I stay in bed.

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 can manage if they are conveniently positioned (i.e. 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 light weights.
___ I cannot lift or carry anything at all.

WALKING

___ Pain does not prevent me from walking any distance.
___ Pain prevents me from walking more than 1 mile.
___ Pain prevents me from walking more than ½ mile.
___ Pain prevents me from walking more than ¼ mile.
___ I can only walk using a cane or a crutch.
___ I am in bed most of the time and must to crawl to the toilet.

SITTING

___ I can sit in any chair as long as I like.
___ I can only sit in my favorite chair for as long as I like.
___ Pain prevents me from sitting for more than 1 hour.
___ Pain prevents me from sitting for more than 30 minutes.
___ Pain prevents me from sitting for more than 10 minutes.
___ Pain prevents me from sitting at all.

STANDING

___ I can stand as long as I want without pain.
___ I can stand as long as I want, but it causes extra pain.
___ Pain prevents me from standing more than 1 hour.
___ Pain prevents me from standing for more than 30 minutes.
___ Pain prevents me from standing for more than 10 minutes.
___ Pain prevents me from standing at all.

SLEEPING

___ Pain does not prevent me from sleeping well.
___ I can sleep well only by using medication / pills.
___ Even when I take meds I will sleep less than 6 hours.
___ Even when I take meds I will sleep less than 4 hours.
___ Even when I take meds I will sleep less than 2 hours.
___ Pain prevents me from sleeping at all.

SEX LIFE

___ My sex life is normal and causes no extra pain.
___ My sex life is normal, but causes extra pain.
___ My sex life if nearly normal, but is very painful.
___ My sex life is severely restricted by pain.
___ My sex life is nearly absent because of pain.
___ Pain prevents any sex life at all.

SOCIAL LIFE

___ My social life is normal and without extra pain.
___ My social life is normal, but results in extra pain.
___ Pain has no significant effect on my social life apart from limiting my more energetic interests (i.e. dancing, etc.)
___ Pain has restricted my social life and I do not go out as often as I would like.
___ Pain has restricted my social life to my home.
___ I have no social life because of pain.

TRAVELING

___ I can travel anywhere without extra pain.
___ I can travel anywhere, but it causes extra pain.
___ Pain is bad, but I can manage journeys over 2 hours.
___ Pain restricts me to journeys less than 1 hour.
___ Pain restricts me to short necessary trips under ½ hour.
___ Pain restricts me from all travel, except to the doctor or hospital.

CURRENT CHIEF COMPLAINT

DIRECTIONS: Please place an "***X***" in all appropriate complaint areas and circle the appropriate side(s) where the pain is.

SPINE

____ Low Back R L ____ Mid Back R L ____ Upper Back R L ____ Neck R L ____ Pelvis R L

UPPER EXTREMITY

____ Shoulder R L ____ Arm R L ____ Elbow R L

____ Forearm R L ____ Wrist R L ____ Hand R L

LOWER EXTREMITY

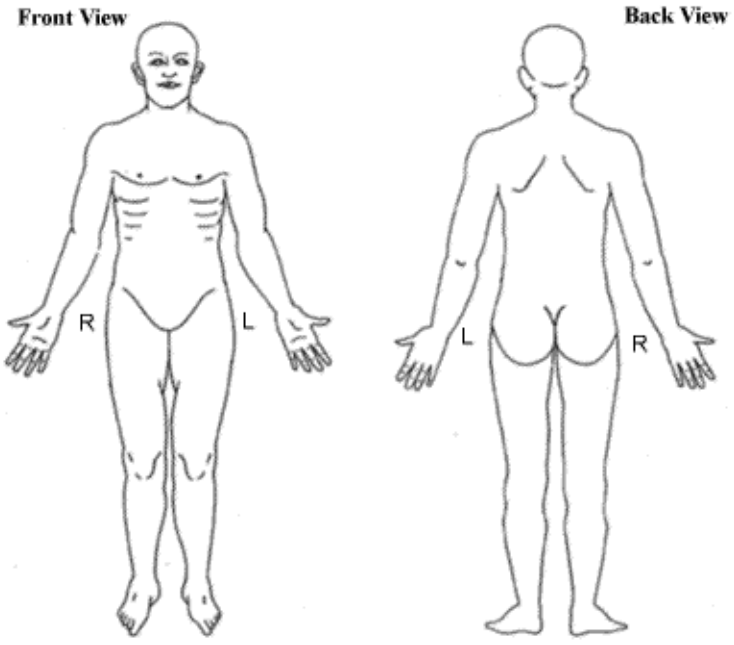
____ Hip R L ____ Thigh R L ____ Knee R L

____ Lower Leg R L ____ Ankle R L ____ Foot R L

OTHER

Please describe: _____

_____



SUBJECTIVE PAIN LEVEL

Please rate your pain(s) on a scale from 0 – 10.

____ **0** – *No Pain*

____ **1** – *Low Pain*
____ **2** – *Low Pain* Location: _____
____ **3** – *Low Pain*

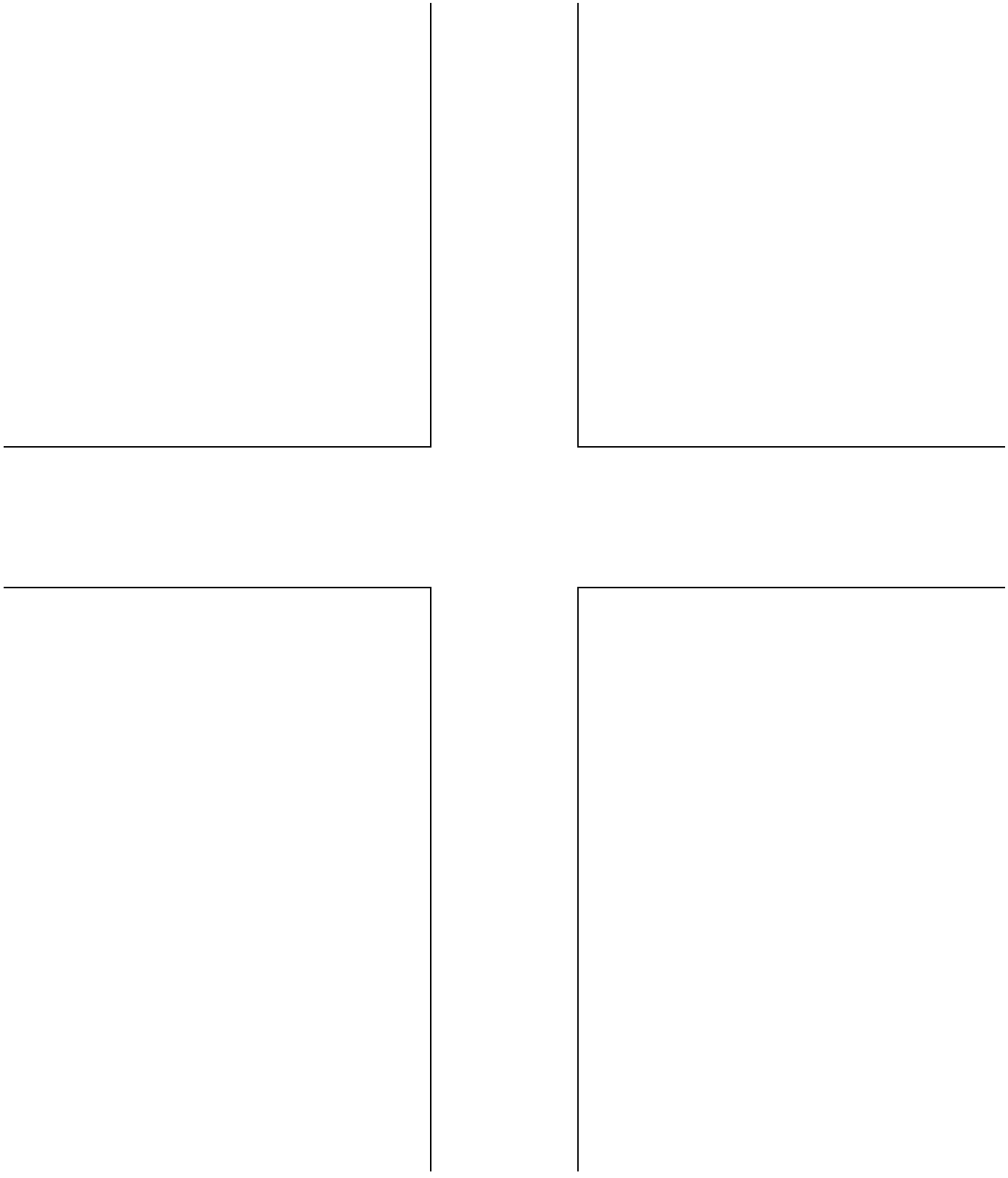
____ **4** – *Moderate Pain*
____ **5** – *Moderate Pain* Location: _____
____ **6** – *Moderate Pain*

____ **7** – *Intense Pain*
____ **8** – *Intense Pain* Location: _____
____ **9** – *Intense Pain*

____ **10** – *Emergency* Location: _____

PLEASE ILLUSTRATE ON THE DIAGRAMS WHERE YOUR PAIN IS LOCATED.

PLEASE DRAW HOW THE ACCIDENT OCCURRED



Naturally CHIROPRACTIC, P.C.

ASSIGNMENT OF BENEFITS

This authorization, or photocopy thereof, authorizes the assignment of benefits directly to Naturally Chiropractic, P.C. (*B. Burford, D.C. / L. Milanovich, D.C. / C. Stack, D.C.*) for injuries to _____
[PATIENT'S NAME]

sustained on _____.
[DATE OF INJURY]

_____ _____
Patient's / Guardian's Signature *Date*

Auto Insurance Carrier: _____
(of vehicle in accident)

Policy # _____

- *This information can be found on the automobile insurance card that must be carried in the vehicle at all times.*

Naturally CHIROPRACTIC, P.C.

NO FAULT INSURANCE AGREEMENT

Name of Policy Holder: _____ *Phone #* _____

Address: _____

Name of Insurance Company: _____ *Policy #* _____

Insurance Company Phone # _____

By signing below, I understand and acknowledge:

1. That in the event that the no-fault insurance company refuses to make payments for services rendered by Naturally Chiropractic, P.C., I will become personally responsible for and agree to settle any outstanding balances and amounts owed.

2. Any insurance checks that are forwarded to me by the no-fault insurance company for services rendered at Naturally Chiropractic, P.C., will be endorsed and turned over to Naturally Chiropractic within five (5) working days in order to settle outstanding balances and amounts owed.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____