Motor Vehicle Accident Information

Last Name:		Social Security no.:
First Name:	DOB: / /	Middle:

General Information

Date of Accident:			
Location (Circle one)	**Driver:** Self Someone else, (who):		
	Passenger	Location (circle one)	Front / Middle / Rear
		Position (circle one)	Left / Middle / Right

Work from Left to Right and Circle One Per Section

Your Vehicle		
	Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Action :	Stopped / Slowing / Acceleration / Cruising
	Speed : (MPH)	
	Time of Accident:	Day Light / Dawn / Dusk / Dark
	Road Condition :	Dry / Damp / Wet / Snow / Ice
	Visibility :	Good / Fair / Poor

Enter impact Information for up to three Vehicles or Objects

Impact Information: Vehicle or Object (I)

(Select one) ☐ **Vehicle** ☐ **Object**		
	Name Object :	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Damage to Your Vehicle:	Minimal / Moderate / Extensive / Totaled / Unsure / Repair Amount $_______
Describe Impact		

Impact Information: Vehicle or Object (II)

(Select one) ☐ **Vehicle** ☐ **Object**		
	Name Object :	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Damage to Other Vehicle:	Minimal / Moderate / Extensive / Totaled / Unsure
Describe Impact		

Impact Information: Vehicle or Object (III)

(Select one) ☐ **Vehicle** ☐ **Object**		
	Name Object :	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Damage to Other Vehicle:	Minimal / Moderate / Extensive / Totaled / Unsure
Describe Impact		

During Impact Information:

Seat Belt?	☐ Yes	☐ No	Brakes Applied ?	☐ Yes	☐ No
Air Bag Deployed?	☐ Yes	☐ No	Seat Broken ?	☐ Yes	☐ No
Seat Back position Changed?	☐ Yes	☐ No			

Head Rest Position : (Circle one)	Low / Mid / High / None
Prepared for Accident?: (Circle One)	Un-expected / Expected / Expected and Braced
Body Position : (Circle one)	Straight / Rotated Left / Rotated Right / Unsure / Other:
Body Thrown?	☐ Yes / ☐ No
Direction of Throw :(Circle One)	Backwards / Forward / Outside / Unsure / Other:

(Circle One)

Head Position :	Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:
Head Motion :	Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other:

Body Impact (Indicate any parts of your body that were struck during the impact)

☐ Head	☐ Upper Back	☐ Right hand	☐ Lower Back
☐ Left Shoulder	☐ Left Leg	☐ Mid Torso	☐ Right Foot
☐ Left Arm	☐ Right Leg	☐ Mid Back	☐ Left Foot
☐ Left Elbow	☐ Right Shoulder	☐ Right Knee	☐ Other :
☐ Left hand	☐ Right Arm	☐ Left Knee	
☐ Upper Front Torso	☐ Right Elbow	☐ Lower Front Torso	

After Accident Information:

Immediately After Accident:	☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Unconscious ☐/Other:

Pain (Indicate if you experienced any pain immediately following the accident)

☐ Head	☐ Left foot	☐ Right foot	☐ Left Knee
☐ Left Hand	☐ Left Shoulder	☐ Right Shoulder	☐ Right knee
☐ Right Arm	☐ Left Elbow	☐ Left Arm	☐ Other :
☐ Upper Front Torso	☐ Mid Torso	☐ Right elbow	
☐ Upper Back	☐ Mid back	☐ Lower Front Torso	
☐ Left Leg	☐ Right Leg	☐ Lower Back	

Numbness:	☐Left Hand ☐ Right Hand ☐ Left Leg ☐ Right Leg ☐ Left Upper Arm ☐ Right Upper Arm ☐ Left Foot ☐ Right Foot ☐ Other:

Medical Information (Did you get medical care for this accident before coming to our office)

Medical Care?	☐ Yes	☐ No

Time of care	Next day / At time of Accident / Later that Day / Days Later: (Specify)
Transported	Drove Self / Ambulance / Other
Went To	Orthopedic / Chiropractor / Neurologist / Family Doctor / ER / Other:(Specify)
Admitted to Hospital?	☐ Yes ☐ No Days Spent in Hospital:
Test:	☐ X-ray ☐ Lab Work ☐ MRI ☐ CT Scan ☐ Other:(Specify)
Treatment:	☐ Ice Pack ☐ Hot Pack ☐ None ☐ Cervical Collar ☐ Medication ☐ Other:(Specify)

Previous Injuries

Previous Injuries / Accidents	☐ No ☐ Yes, Specify:
Residual pain from Previous Injuries/Accidents	☐ No ☐ Yes, Specify:

Later Symptoms (Please note any symptoms that started after the accident occurred)

Head	☐ Headache ☐ Dizziness ☐ Blurred Vision ☐ Light Headedness ☐ Loss of Vision ☐ Fainting ☐ Loss of Memory ☐ Pain in ear ☐ Double Vision ☐ Other Specify:
Neck (with Movement)	☐ Pain in Neck ☐ Forward ☐ Backward ☐ Turn Left ☐ Popping in Neck ☐ Muscle Spasms ☐ Turn Right ☐ Bend Left ☐ bend Right ☐ Other Specify:
Shoulders	☐ Pain in Shoulder joint ☐ Tension in shoulders ☐ Muscle Spasms in Shoulder ☐ Pain across shoulder ☐ Cant raise arms above [ ] Above shoulder level [ ] Over head ☐ Other Specify:
Arms and Hands	☐ Pain in Fingers ☐ Numbness in Left Arm ☐ Hands Cold ☐ Pin & needles in hands ☐ Numbness in Right Arm ☐ Loss of Grip Strength ☐ Pin & needles in fingers ☐ Swollen joints in Fingers ☐ Other Specify:
Chest	☐ Chest pain ☐ Pain Around Ribs ☐ Shortness of Breadth ☐ Breast Pain ☐ Other Specify:
Abdomen	☐ Nervous Stomach ☐ Nausea ☐ Diarrhea ☐ Gas ☐ Constipation ☐ Other Specify:
Mid back	☐ Sharp Stabbing ☐ Mid pain back ☐ Pain From front to back ☐ Dull Ache ☐ Pain in Kidney Area ☐ Muscle Spasms ☐ Pain between shoulders ☐ Other Specify:
Lower Back	☐ Low Back Pain Low back pain is worse when ☐ Working ☐ Lifting ☐ Stooping ☐ Standing ☐ Sitting ☐ Bending ☐ Coughing ☐ Lying Down ☐ Muscle Spasms ☐ Other Specify:
Hips, Legs & Feet	☐ Pain in Buttocks ☐ Pain and needles in Legs ☐ Pain down leg ☐ Pain in hip joint ☐ Feet feel Cold ☐ Swollen Feet ☐ Numbness in Toes ☐ Numbness of Leg ☐ Knee pain ☐ Leg cramps ☐ Cramps in Feet ☐ Other Specify:
General	☐ Nervousness ☐ Fatigue ☐ Irritable ☐ Depressed ☐ Generally Feel Rundown ☐ Prostate Pain/Swelling ☐ Difficulty Urinating ☐ Night Urination ☐ Cramping ☐ Irregularity Hours of Sleep Lost per Night : [________________________] hrs per night Amount of Weight Lost or Gained as result : [________________________] lbs Amount of time lost from work : [________________________] Days/week(s)/Months • Income Lost? ______________________ Other:

Signature: ____________________________________ Date: ______________________

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

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

Name:__________________________ Signature:______________________________ Date: __________

Section 1 – Pain Intensity

I have no pain at the moment.
The pain is mild at the moment.
The pain comes and goes and is moderate.
The pain is moderate and does not vary much.
The pain is severe but comes and goes.
The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

I can look after myself 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 can if they are conveniently positioned, for example 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 lift very light weights.
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 cannot read as much as I want because of moderate pain in my neck.
I cannot read as much as I want 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 which come infrequently.
I have moderate headaches which come infrequently.
I have moderate headaches which come frequently.
I have severe headaches which 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 cannot do any work at all.

Section 8 – Driving

I can drive my car without 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 cannot drive my car as long as I want because of moderate pain in my neck.
I can hardly drive my car at all because of severe pain in my neck.
I cannot drive my car at all.

Section 9 – Sleeping

I have no trouble sleeping.
My sleep is slightly disturbed (less than 1 hr. sleepless).
My sleep is mildly disturbed (1-2 hours sleepless).
My sleep is moderately disturbed (2-3 hours sleepless).
My sleep is greatly disturbed (3-5 hrs. sleepless).
My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

I am able engage in all recreational activities with no pain in my neck at all.
I am able engage in all recreational activities with some pain in my neck.
I am able engage in most, but not all recreational activities because of pain in my neck.
I am able engage in a few of my usual recreational activities because of pain in my neck.
I can hardly do any recreational activities because of pain in my neck.
I cannot do any recreation activities at all.

Balanced Life Chiropractic — Oswestry Low Back Questionnaire

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

Name:___________________________ Signature:________________________________ Date: ___________

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 and 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 from lifting heavy weights off the floor.
Pain prevents me from lifting heavy weights off the floor but I can 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 with walking but it does not increase with distance.
I cannot walk more than One Mile without increasing pain.
I cannot walk more than 1/2 Mile without increasing pain.
I cannot walk more than 1/4 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 only sit in my favorite chair as long as I like.
Pain prevents me from sitting more than one hour.
Pain prevents me from sitting more than 30 minutes.
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 1/2 hour without increasing pain.
I cannot stand for longer than 10 minutes without increasing pain.
I avoid standing because it increases 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 nights sleep is reduced by less than 1/4.
Because of pain my normal nights sleep is reduced by less than 1/2.
Because of pain my normal nights sleep is reduced by less than 3/4.
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 my 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 social life to my home.
I have hardly any social life because of the pain.

Section 9 – Traveling

I get no pain while traveling.
I get some pain while traveling but none of my usual sorts of travel make it any worse.
I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
I get extra pain while traveling 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 the present.
My pain is neither getting better or worse.
My pain is gradually worsening.
My pain is rapidly worsening.