ASPEN RIDGE
CHIROPRACTIC

Automobile Accident History Form

Your Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ am/pm

Road conditions at the time of accident: WET DRY ICY OTHER

Did the police come to the accident scene? YES NO

Is there a report? YES NO Did you request the report? YES NO

Did you go to the hospital? YES NO _____

If yes, what Hospital? _____

How did you get to the hospital? _____

What parts of your body were x-rayed at the hospital? _____

What did the hospital I do for your injuries? _____

How long did you stay at the hospital? _____

What bleeding cuts did you sustain during this accident? _____

What bruises did you sustain during this accident?_____

Where were you seated in the vehicle?

DRIVER FRONT PASSENGER LEFT REAR MIDDLE REAR RIGHT REAR

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise'?

AWARE SURPRISED

Did you lose consciousness (black out) upon impact? YES NO: How long: _____

Did you experience a flash of light or explosion in your head') YES NO

Did you become one of the following from the accident')

CONFUSED DISORIENTED LIGHTHEADED DIZZY

NAUSEATED BLURRED VISION RING/BUZZ IN EARS

If you still have any of those symptoms, which ones are still occurring? _____ _

Are you currently suffering from any of the following?

DIFFICULT CONCENTRATING
REDUCED TOLERANCE TO HEAT
REDUCED TOLERANCE TO ALCOHOL
RESTLESSNESS
DIFFICULTY WITH MEMORY
IRRITABLE
SLEEPLESSNESS
CHILLS
FORGETFULNESS

How far is the top of the headrest or seat back from the top of your head (approximately):

_____ _____ inches above or below?

Were you wearing a seat belt? YES NO

If yes, was it a LAP SEATBELT or a SHOCLDER-LAP SEATBELT?

List the year, make and model of the vehicle you were in:

Year _____ Make _____Model _____

Was your car stopped at the time of impact? YES NO

If yes, was the driver's foot also on the brake? YES NO

If no, then estimate the speed of the vehicle you were in _____mph

If your vehicle was moving at the time of impact, was it:

Slowing Down? YES NO

Gaining Speed? YES NO

Traveling at a steady rate of speed? YES NO

On what part of the automobile did your following body parts hit?

Head Hit _____

Right/ left shoulder hit _____

Right/left hip hit _____

Right/left knee hit _____

Chest hit _____

Right/left arm hit _____

Right/left leg hit _____

Other _____

Did you receive any injury or bruise from the seat belt? YES NO

If YES then describe:

What is the estimated cost damage to the vehicle you were in? $_____

Which of the following car parts broke during the accident?

WINDSHIELD FRONT SEAT BACK RIGHT/LEFT SIDE WINDOW

STEERING WHEEL OTHER

Was the trunk of your body pointed straight forward at the time of the collision? YES NO

If no, how was it turned? _____ _____ _

Was you head pointed straight forward? YES NO

If no, what direction was it turned and by how much? _____

What is the year, make and model of the other vehicle?

Year _____Make _____Model _____

Was the other vehicle moving at the time of the collision? YES NO

If yes, what was its approximate speed? _____mph

If the other vehicle was moving at the time of the collision, was it:

SLOWING DOWN GAINING SPEED TRAVELING AT A STEADY SPEED

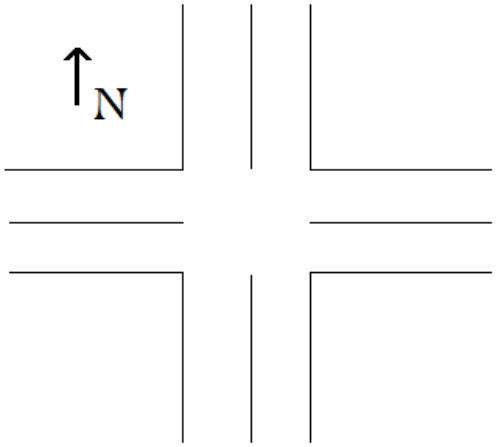
Pease describe, to the best of your knowledge, what happened during the accident:

_____

_____

_____

_____



Thank you for taking the time to fill out this form

Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name _____ Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Who referred you to our office? _____

(Indicate if child. student. housewife. unemployed. retired)

Social Sec. # _____ Business Phone _____ Company Name _____ Location _____

Spouse's First Name _____ Spouse's Soc. Sec. # _____ Spouse's Employer _____ Location _____

Please explain in detail how your accident happened

_____

_____

_____

Insurance Co._____ Policy No._____ Claim No. _____

Driver of other vehicle (if any)

Name _____ Insurance Company _____ Policy No._____

Driver of vehicle in which you were injured (if applicable)

Name _____ Insurance Company _____ Policy No._____

Name of your insurance adjustor? _____

Have you retained an attorney? ☐Yes ☐No

If so, his name and address _____

You were heading ☐ North ☐ East ☐ South ☐ West on _____ (street or highway)

Other vehicle was headed ☐ North ☐ East ☐ South ☐ West on_____ (street or highway)

Were the police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If so, for how long? _____

You were struck from ☐ Behind ☐ Front ☐ Left side ☐ Right side

You were ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Using seat belts ☐ Other protective devices

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

What treatment was given? _____

Was any other doctor consulted after your accident? ☐ Yes☐ No ☐ D.C., ☐ M.D., ☐ D.O., ☐ D.D.S.

If so, what was the doctor's name? _____

What was the diagnosis?_____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms ☐ Improving ☐ Getting worse ☐ Same

HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes: 1-never had; 2-previously had; 3-presently have,

MUSCULO-SKELETAL SYSTEM

__ Low back problems
__ Pain between shoulders
__ Neck problems
__ Arm problems
__ Leg problems
__ Swollen joints
__ Painful joints
__ Stiff joints
__ Sore muscles
__ Weak muscles
__ Walking problems
__ Ruptures
__ Broken bones

GENITO-URINARY SYSTEM

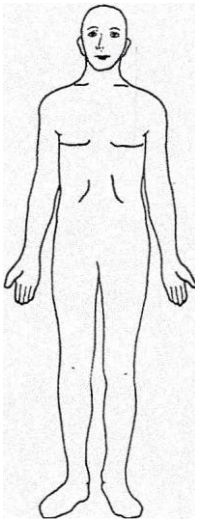
__ Bladder trouble
__ Excessive urination
__ Scanty urination
__ Painful urination
__ Discolored urine

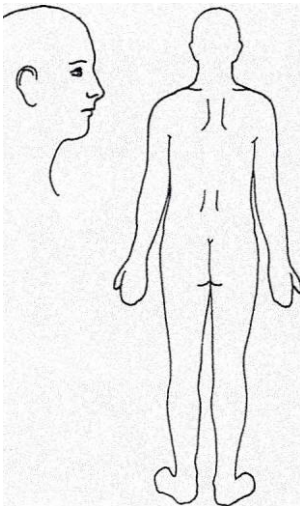
FEMALE

__ Vaginal discharge
__ Vaginal bleeding
__ Vaginal pain
__ Breast pain
__ Lumps on breast

Are you pregnant?
__ Yes __ No

Please mark your areas of pain on the figures below.





GASTRO-INTESTINAL SYSTEM

__ Poor appetite
__ Excessive hunger
__ Difficulty chewing
__ Difficulty swallowing
__ Excessive thirst
__ Nausea
__ Vomiting food
__ Vomiting blood
__ Abdominal pain
__ Diarrhea
__ Constipation
__ Black stool
__ Bloody stool
__ Hemorrhoids
__ Liver trouble
__ Gall bladder problems
__ Weight trouble

NERVOUS SYSTEM

__ Numbness
__ Loss of feeling
__ Paralysis
__ Dizziness
__ Fainting
__ Headaches
__ Muscle jerking
__ Convulsions
__ Forgetfulness
__ Confusion
__ Depression

CARDIO-VASCULAR· RESPIRATORY

__ Chest pain
__ Pain over heart
__ Difficulty breathing
__ Persistent cough
__ Coughing phlegm
__ Coughing blood
__ Rapid heartbeat
__ Blood pressure problems
__ Heart problems
__ Lung problems
__ Varicose veins

EYE, EAR, NOSE, AND THROAT

__ Eye strain
__ Eye inflammation
__ Vision problems
__ Ear pain
__ Ear noises
__ Hearing loss
__ Ear discharge
__ Nose pain
__ Nose bleeding
__ Nose discharge
__ Difficult breathing thru nose
__ Sore gums
__ Dental problems
__ Sore mouth
__ Sore throat
__ Hoarseness
__ Difficult speech

_____
Patient's Signature

……DO NOT WRITE BELOW THIS LINE .....

_____
_____
_____
_____
_____
_____
_____

Patient accepted? ☐ Yes ☐ No Doctor's Signature _____

ASPEN RIDGE
CHIROPRACTIC

Patient Name (Print) _____ Date _____

Signature _____

Oswestry Low Back Pain Questionnaire

PLEASE READ: This questionnaire is designed to enable your health care provider to understand how much your **low back pain** has affected your ability to manage everyday activities. Answer each section by circling the **ONE** choice that most applies to you. We realize 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.**

Section 1 – Pain Intensity
- A. I have no pain at the moment.
- B. The pain is 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.

Section 2 – Personal Care
- 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, wash with difficulty and stay in bed.

Section 3 – Lifting
- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights but it gives me extra pain.
- C. Pain prevents me from lifting heavy weights off the floor but I can if they are in convenient places.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage medium weights.
- E. I can only lift very light weight.
- F. I cannot lift or carry anything.

Section 4 – Walking
- 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 ½ mile.
- D. Pain prevents me from walking more than ¼ mile.
- E. I can only walk using a cane or crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting
- A. I can sit in a chair as long as I like.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than 1 hour.
- D. Pain prevents me from sitting more than ½ hour.
- E. Pain prevents me from sitting more than 10 minutes.
- F. Pain prevents me from sitting at all.

Section 6 – Standing
- A. I can stand as long as I like without extra pain.
- B. I can stand as long as I want but it gives me extra pain.
- C. Pain prevents me from standing for more than 1 hour.
- D. Pain prevents me from standing for more than 30 minutes.
- E. Pain prevents me from standing for more than 10 minutes.
- F. Pain prevents me from standing at all.

Section 7 – Sleeping
- A. My sleep is never disturbed by pain.
- B. My sleep is occasionally disturbed by pain.
- C. Because of pain I have less than 6 hours sleep.
- D. Because of pain I have less than 4 hours sleep.
- E. Because of pain I have less than 2 hours sleep.
- F. Pain prevents me from sleeping at all.

Section 8 – Social Life
- A. My social life is normal and gives me no pain.
- B. My social life is normal but increases the degree of pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests.
- 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 no social life because of the pain.

Section 9 – Traveling
- A. I can travel anywhere without pain.
- B. I can travel anywhere but it gives me extra pain.
- C. Pain is bad but I manage journeys over two hours.
- D. Pain restricts me to journeys of less than one hour.
- E. Pain restricts me to short necessary journeys under 30 minutes.
- F. Pain prevents me from traveling except to receive treatment

Section 10 – Changing Degree of Pain
- A. My normal homemaking/job activities do not cause pain.
- B. My normal homemaking/job activities increase my pain, but I can still perform these tasks.
- C. I can perform most of my homemaking/job activities, except for my physically stressful activities.
- D. Pain prevents me from doing anything but light duties.
- E. Pain prevents me from doing even light duties.
- F. Pain prevents me from performing any job or homemaking chores.

Comments:

(For Office Use Only)
Oswestry #

The Neck Disability Index

PLEASE READ: This questionnaire has been designed to give the doctor information as to how your **neck pain** has affected your ability to manage everyday life. Please answer each section by circling the **ONE** choice that most applies to you. We realize 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.**

Section 1 – Pain Intensity

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.

Section 2 – Personal Care (washing, dressing, etc.)

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 was with difficulty and stay in bed.

Section 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are in convenient places.
D. Pain prevents me from lifting heavy weights but I can manage medium weights if conveniently positioned.
E. I can only lift very light weights.
F. I cannot lift or carry anything.

Section 4 – Reading

A. I can read as much as I want 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 with moderate pain.
D. I can't read as much as I want because of moderate pain in my neck.
E. I can hardly read at all because of severe pain in my neck.
F. I cannot read at all.

Section 5 – Headaches

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have slight headaches which come frequently.
D. I have moderate headaches which come infrequently.
E. I have moderate headaches which come frequently.
F. I have headaches almost all the time.

Section 6 – Concentration

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.
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.

Section 7 – Work

A. I can do as much work as I want to.
B. I can 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 can’t do any work at all.

Section 8 – Driving

A. I 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 can't drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I can't drive my car at all.

Section 9 – Sleeping

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hr sleepless).
C. My sleep is moderately disturbed (1-2 hrs sleepless).
D. My sleep is moderately disturbed (2-3 hrs sleepless).
E. My sleep is greatly disturbed (3-5 hrs sleepless).
F. My sleep is completely disturbed (5-7 hrs sleepless).

Section 10 – Recreation

A. I am able to engage in all my recreation activities with no neck pain at all.
B. I am able to engage in all my recreation activities with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
E. I can hardly do any recreation activities because of pain in my neck.
F. I can't do any recreation activities at all.

Comments:

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