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

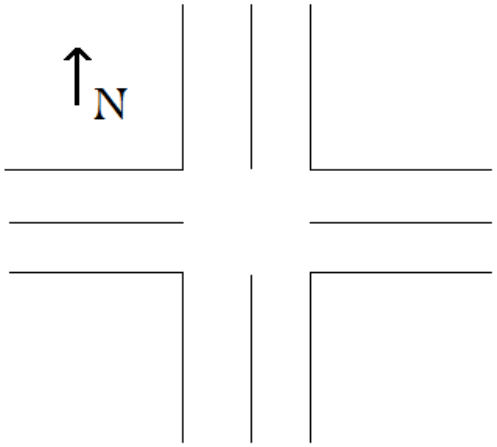
Pease describe, to the best of your knowledge, what happened during the accident:

_____

_____

_____

_____



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

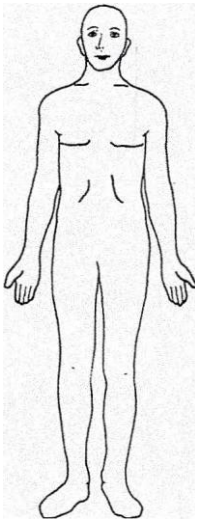
__ Bladder trouble
__ Excessive urination
__ Scanty urination
__ Painful urination
__ Discolored urine

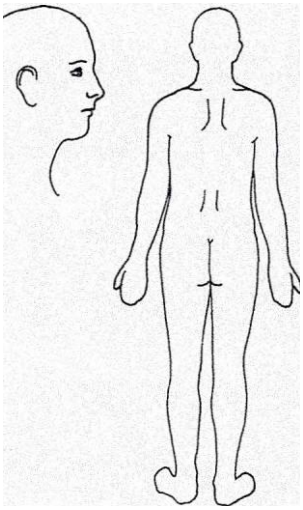
FEMALE

__ 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 _____

The Neck Disability Index

Patient name: _____ File#_____ Date:_____

Please read instructions:

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 every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box 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 (Washing, Dressing, etc.)

- ☐ 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 gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights off the floor, 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 to, 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 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 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs 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 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 neck pain at all.
- ☐ 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 few of my 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.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

ASPEN RIDGE
CHIROPRACTIC

Revised Oswestry Low Back Pain Questionnaire

Revised Oswestry

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 RTIGHT NOW.**

Section 1 – Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

Section 2 – Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing and dressing even though it causes some pain.
C. Washing and dressing increase the pain but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do *some* washing and dressing without help.
F. Because of the pain I am unable to do *any* washing and dressing without help.

Section 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table)
E. I can only lift very lift weights, at the most.

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 while using a cane or on 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 without paint.
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 pain.
B. I have some pain while standing but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. I avoid standing because it increases the pain straight away.

Section 7 – Sleeping

A. I get no pain in bed.
B. I get pain in bed but it does not prevent me from sleeping well.
C. Because of pain my normal night's sleep is reduced by less than ¼.
D. Because of pain my normal night's sleep is reduced by less than ½.
E. Because of pain my normal night's sleep is reduced by less than ¾.
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 (e.g. dancing, etc.)
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 hardly any social life because of the pain.

Section 9 – Traveling

A. I get no pain while traveling.
B. I have some pain while traveling but none of my usual forms of travel make it any worse.
C. I have extra pain while traveling but it does not compel me to seek alternate forms of travel.
D. I get extra pain while traveling that compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

Section 10 – Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at the present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

Name (Print):	Signature:	Date:
Comments:	Oswestry #	