Alternative Wellness & CHIROPRACTIC CENTER

Auto Accident Questionnaire

Patient Information

Date_____ Date of Birth_____

Patient Name_____
First M Last

What do you prefer to be called? _____

Address _____

City _____ State _____ Zip _____

Patient SSN#_____ Do you? ☐ Rent ☐ Own

Sex ☐ Male ☐ Female Language (If other than English)_____

Ethnicity (Mark one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (Mark one or more) ☐ American Indian or Alaska Native ☐ Asian ☐ White

☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

Cell Phone_____ Cell Phone Carrier_____

Home Phone_____ E-mail_____

Occupation _____

Employer/ School_____

Employer/ School Address _____

City _____ State _____ Zip _____

Employer/ School Phone_____

If Minor, Parent/Legal Guardian's Name_____

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name_____

Spouse's Cell Phone _____

Spouse's Employer _____

How did you hear about us?_____

Other Vehicle's Auto Insurance Information

Company_____

Contact_____ Phone_____

Policy Holder_____

Policy Holder's Address, City, State, Zip_____

Claim Adjuster_____

Phone_____ Fax _____

Your Auto Insurance Information

Company_____

Contact_____ Phone_____

Policy Holder_____

Policy Holder's Address, City, State, Zip_____

Claim Adjuster_____

Phone_____ Fax _____

Med Pay? ☐ Yes ☐ No Amount_____ Used _____

Health Insurance

Do you have a Flex Spending (FSA) or Health Savings (HSA) Account? ☐ Y ☐ N

Insurance Company_____

Policy # _____Group #_____

Relationship to the patient ☐ Self ☐ Spouse ☐ Child ☐ Other

* If you selected "self" please stop here and proceed to the next section.

Policy Holder _____
First M Last

Policy Holder's Date of Birth_____ Sex ☐ Male ☐ Female

Policy Holder's Address, City, State, Zip_____

Policy Holder's Employer _____

Employer City _____ State _____ Zip _____

Employer Phone_____

Secondary Health Insurance

Insurance Company_____

Policy # _____Group #_____

Relationship to the patient ☐ Self ☐ Spouse ☐ Child ☐ Other

* If you selected "self" please stop here and proceed to the next section.

Policy Holder _____
First M Last

Policy Holder's Date of Birth_____ Sex ☐ Male ☐ Female

Policy Holder's Address, City, State, Zip_____

Policy Holder's Employer _____

Employer City _____ State _____ Zip _____

Employer Phone_____

Emergency Contact

This must be someone NOT living in your household.

Name:_____Relationship:_____Cell Phone:_____ Home Phone:_____

Address:_____City, State, Zip:_____

Designation of Personal Representative

Name:_____Relationship:_____Cell Phone:_____ Home Phone:_____

Address:_____City, State, Zip:_____

I hereby designate the above named individual as my personal representative who may act on my behalf for the purpose of: Consenting to use and disclosure of my health information, authorizing use and disclosure of my health information, and receiving information that otherwise would be sent me. If I am incapacitated, my personal representative may also sign any form (such as authorization, revocation of authorization, request for access to information and/or billing inquiries), the uses of which are described in privacy policies and procedures. I understand that a person who is identified in my medical record as having medical power of attorney or other legal authority to act on my behalf is additionally recognized as my personal representative. I understand that I have the right to revoke this authorization at any time. Revoking this authorization must be made in writing, signed, and dated.

Details Regarding the Auto Accident

Date of Accident_____ State _____ Time of Accident _____ am/ pm

Were you admitted to the emergency room? ☐ Yes ☐ No
How did you get to the emergency room? _____

Were you released from the emergency room the same day? ☐ Yes ☐ No*
*If no, how long were you admitted? _____

Did you lose consciousness? ☐ Yes ☐ No
What type of treatment did you receive at the hospital?

☐ X-rays ☐ MRI ☐ CAT scan ☐ Medications _____
Other _____

Have you been treated by another doctor for this accident? ☐ Yes ☐ No

Explain_____

Where were you located in the vehicle?_____

Were you wearing your seatbelt at the time of the accident? ☐ Yes ☐ No

Was your seatbelt a harness type of restraint? ☐ Yes ☐ No

Did the air bag deploy and strike you? ☐ Yes ☐ No

Did your body strike anything in the vehicle? ☐ Yes ☐ No ☐ Unsure

Explain_____

Have you been able to work since the injury? ☐ Yes ☐ No
How many days of work have you missed?_____

Has this accident restricted your work performance? ☐ Yes ☐ No

Explain_____

Were there other passengers in the car? ☐ Yes ☐ No How many?_____

Prior to your injury were you able to work on an equal basis with
others your age? ☐ Yes ☐ No

Have you retained an attorney? ☐ Yes ☐ No

Firm Name_____

Phone_____ Fax _____

Were the police notified? ☐ Yes ☐ No
*If yes, please provide a copy of the accident report.

Who was at fault?_____

Was there a traffic violation issued? ☐ Yes* ☐ No
*To whom?_____

What type of vehicle were you struck by?
☐ Small ☐ Mid-Sized ☐ Large ☐ Car ☐ SUV ☐ Truck

What type of vehicle were you riding or traveling in?
☐ Small ☐ Mid-Sized ☐ Large ☐ Car ☐ SUV ☐ Truck

Was your car moving or stopped at the time of impact? ☐ Stopped ☐ Moving

What was the approximate speed of YOUR vehicle?_____mph

What was the approximate speed of the OTHER vehicle? _____mph

Were you aware of the accident before impact? ☐ Yes ☐ No

During impact were you looking ☐ Right ☐ Left ☐ Forward ☐ Backward
☐ Up ☐ Down ☐ Other_____

On what side was the impact to YOUR car?
☐ Front ☐ Back ☐ T-Bone ☐ Driver Side ☐ Passenger Side

Did the vehicle ☐ Flip ☐ Spin ☐ Other_____

What was the position of your headrest?_____

Are there any other details from your accident that could impact your treatment?
_____

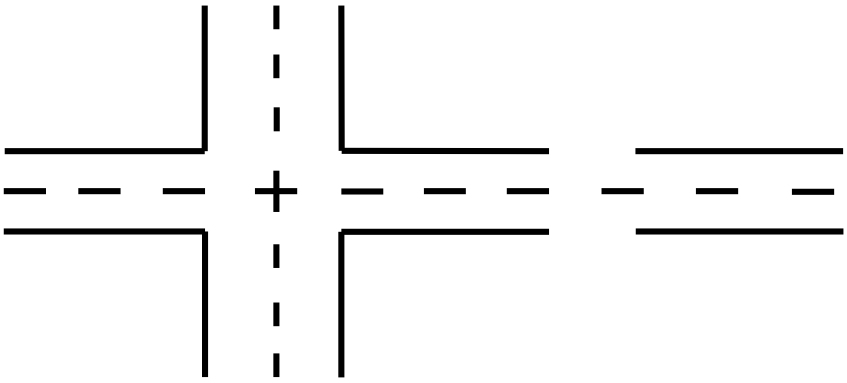
Have you been in other automobile accidents prior to this one? ☐ Yes ☐ No
If yes, Date_____ Date_____ Date_____

Please indicate symptoms that are a result of this accident.

☐ Dizziness ☐ Memory Loss ☐ Numb Hand/ Fingers ☐ Headaches
☐ Irritability ☐ Ears Ringing ☐ Difficulty Sleeping ☐ Nausea
☐ Fatigue ☐ Jaw Problems ☐ Shortness of Breath ☐ Chest Pain
☐ Tension ☐ Blurred Vision ☐ Numb Feet/ Toes ☐ Upset Stomach

PLEASE use the diagram below to describe how your auto accident occurred. If there are additional details, list here. Write down street names.

_____
_____
_____



Please indicate: NORTH

Authorization and Medical Release

I affirm that the above information is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status. I authorize the doctor to treat my condition as he deems appropriate and to grant full disclosure for all previous or concurrent care. I agree to grant full indemnity to Alternative Wellness and Chiropractic Center and it's physicians for complications related to all pre-existing conditions medically diagnosed or otherwise not disclosed.

Patient or Guardian Signature_____ Date _____

Print Guardian Name _____ Relationship to Patient_____

Alternative Wellness & CHIROPRACTIC CENTER

Name:_____

I. HEALTH HISTORY

Do you smoke?* ☐ Y ☐ N ☐ Social ☐ Quit

Current Medication:*_____

_____

☐ I will provide a list of my medications.

Allergies:*_____

_____

Medication Intolerance:*_____

_____

Personal Disease/Illness

List any past history of disease/illness *Month/Year*

_____

_____

_____

Family Disease/Illness

List any family history of disease/illness *Relationship* *Month/Year*

_____

_____

_____

Hospitalizations/Surgeries/Injuries

List Past Hospitalizations/Surgeries/Injuries *Month/Year*

_____

_____

_____

Primary Physician(s) _____

_____

Date of Last Exam _____

Date of Last X-ray _____

II. REVIEW OF SYSTEMS

Have you at any time had: *(Check all that apply)*

Head and Neck

☐ Decreased hearing
☐ Ringing in ears
☐ Frequent ear infections
☐ Dizzy spells
☐ Failing vision
☐ Double or blurred vision
☐ Eye pain
☐ Repeated eye infections
☐ Recurrent nose bleeds
☐ Sinus/throat infections

Cardiovascular

☐ High blood pressure*
☐ Pain (chest, arms or legs)
☐ Palpitations
☐ Irregular heart beat
☐ Swollen ankles
☐ Fainting spells

Digestive

☐ Difficulty swallowing
☐ Indigestion or heartburn
☐ Nausea/vomiting
☐ Diarrhea
☐ Constipation
☐ Blood in bowel movement
☐ Black bowel movement

Neurological/Physc

☐ Numbness/Tingling
☐ Headache
☐ Nervousness
☐ Memory Loss
☐ Moodiness
☐ Difficulty falling asleep
☐ Difficulty staying awake
☐ Increased irritability
☐ Depression/Anxiety

Endocrine

☐ Chronic fatigue
☐ Weight gain/Weight Loss (recent)
☐ Bruise easily
☐ Cold extremities
☐ Tremors (shaking of hands)
☐ Convulsions
☐ Muscle weakness

Respiratory

☐ Hoarseness
☐ Persistent cough
☐ Blood in spit
☐ Shortness of breath

Skin

☐ Rash
☐ Hives
☐ Moles (cancerous)

Genitourinary

☐ Diabetes*
☐ Painful urination
☐ Blood in urine
☐ Frequent urination
☐ Frequent night time urination
☐ Loss of control of urine
☐ Sexual dysfunction

Musculoskeletal

☐ Neck pain
☐ Joint swelling
☐ Mid back pain
☐ Low back pain
☐ Foot pain
☐ Stiff joints

Other Symptoms

_____

Women Only

Are you pregnant? Y N If Yes, Last Menstrual Period_____ Due Date_____

Are you nursing? Y N Are you planning a pregnancy? Y N

- ☐ Breast tenderness associated with cycle
- ☐ Breast fibroids, benign masses
- ☐ Menstruation Problems
- ☐ Uterine fibroids
- ☐ Endometriosis
- ☐ Vaginal discharge, dryness, itchiness
- ☐ Thyroid Problems
- ☐ Hot flashes
- ☐ Night sweats (in menopausal females)
- ☐ Urinary Tract, bladder, kidney infections
- ☐ Other _____

Men Only Do you experience any of the following? *(Check all that apply)*

- ☐ Prostate problems
- ☐ Difficulty with urination, dribbling
- ☐ Difficult to start and stop urine stream
- ☐ Pain or burning with urination
- ☐ Interruption of stream during urination
- ☐ Pain on inside of thighs, legs or heels
- ☐ Feeling of incomplete bowel evacuation
- ☐ Decreased sexual function
- ☐ Other _____

III. REASONS FOR SEEKING CARE

Present Complaints

1. _____**How long has this been an issue?**_____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in morning ☐ Worse in evening ☐ Pain radiates to_____

2. _____**How long has this been an issue?**_____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in morning ☐ Worse in evening ☐ Pain radiates to_____

3. _____**How long has this been an issue?**_____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in morning ☐ Worse in evening ☐ Pain radiates to_____

4. What makes it better?_____

5. What makes it worse?_____

6. What Doctor's have you seen for this?_____

7. Type of treatment:_____

8. Results:_____

Rate your pain 0 to 10, ten being the worst

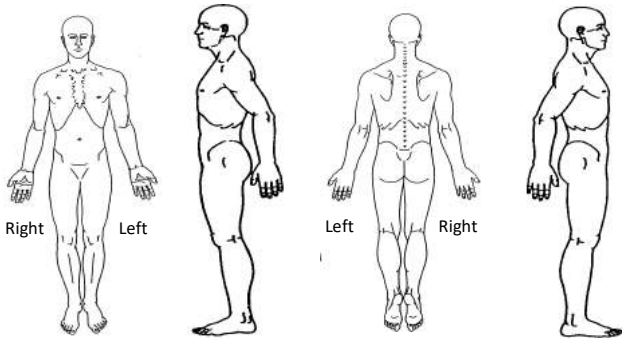
Neck Pain
0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain
0 1 2 3 4 5 6 7 8 9 10

Low Back, Hip Pain
0 1 2 3 4 5 6 7 8 9 10

Other Pain _____
0 1 2 3 4 5 6 7 8 9 10

Mark <u>ALL</u> areas of pain on figures below



IV. CERTIFICATION

I certify that I have read and understand the above information. I acknowledge that I have answered the above questions correctly and to the best of my ability. I will not hold my chiropractor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature_____ Date _____

(Office Use Only)

The above health history questionnaire was reviewed by _____(Physician) Date _____

Neck Pain Index

Please read: This questionnaire is designed to enable us to understand how much your **neck pain** has affected your ability to manage everyday activities. Please answer each section by checking the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just check the one choice which closely describes your problem *right now***.

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 I manage most of my personal care.
- ☐ I need some help in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and I 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 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 HEADACHE

- ☐ 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 with no difficulty.
- ☐ I can concentrate fully, when I want with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating when I want to.
- ☐ I have a lot of difficulty concentrating when I want to.
- ☐ I have a great deal of difficulty 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 at all.

Section 9 SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleeping is slightly disturbed. (less than 1hour 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 hours sleepless)
- ☐ My sleep is completely disturbed. (5-7 hours sleepless)

Section 10 RECREATION

- ☐ I am able to engage in all recreational activities with no pain in my neck at all.
- ☐ I am able to engage in all recreational activities with some pain in my neck.
- ☐ I am able to engage in most but not all recreational activities because of my neck pain.
- ☐ I am able to 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 recreational activities at all.

Signature _____

Date _____ File # _____ Disability Index Score: _____ Improvement _____ %

Oswestery Disability Index

Low Back Disability Index

Please read: This questionnaire is designed to enable us to understand how much your **low back pain** has affected your ability to manage everyday activities. Please answer each section by checking the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just check the one choice which closely describes your problem *right now***.

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, ect.)
- ☐ 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 of my washing and dressing without help.

Section 3 Lifting
- ☐ I can lift 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 form 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 on walking but it does not increase with distance.
- ☐ I can not walk more than one mile without increasing pain.
- ☐ I can not walk more than ½ mile without increasing pain.
- ☐ I can not walk more than ¼ mile without increasing pain.
- ☐ I can not walk at all with out increasing pain.

Section 5 Sitting
- ☐ I can sit in a chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain.

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 can not stand for longer than one hour without increasing pain.
- ☐ I can not stand longer than ½ hour without increasing pain.
- ☐ I can not stand longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

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 my pain, my normal nights sleep is reduced by less than ¼.
- ☐ Because of my pain, my normal nights sleep is reduced by less than ½.
- ☐ Because of my pain, my normal nights sleep is reduced by lees than ¾.
- ☐ Pain prevents me from sleeping at all.

Section 8 Social Life
- ☐ My social life is normal and gives my no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, ect.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my 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 forms 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 alternate forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents me from all forms of travel except that dome lying down.

Section 10 Changing Degree of Pain
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall it is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow.
- ☐ My pain is neither getting better nor getting worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Signature _____

Date _____ File # _____ Disability Index Score: _____ Improvement _____ %

Revised Oswestery Disability