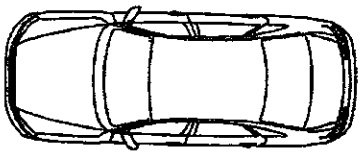
Accident History Questionnaire

BACK 2 BACK CHIROPRACTIC
A Family Wellness Place

PERSONAL INJURY PATIENT HISTORY

Name _____ Date _____

1. Date of Accident: _____ 2. Time: _____ AM/PM
3. Driver of Car: _____
4. Where were you seated? _____
5. Who owns the car? _____
6. Year & Model of your car: _____
   Year & Model of other car: _____
7. What was the approximate damage done to your car? $_____
8. Visibility at time of accident: ☐ poor ☐ fair ☐ good ☐ other: _____
9. Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dark
   ☐ other (describe): _____
10. Where was your car struck?

FRONT  REAR

In your own words, please describe accident: _____
_____
_____

11. Type of accident: ☐ Head-on collision ☐ Broad-side collision ☐ Front impact
    ☐ Rear-end car in front ☐ Rear impact ☐ Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: _____
13. Did you see the accident coming? ☐ Yes ☐ No
14. Did you brace for impact? ☐ Yes ☐ No
15. Were seatbelts worn? ☐ Yes ☐ No
16. Were shoulder harnesses worn? ☐ Yes ☐ No
17. How was the shoulder harness adjusted? ☐ Loose ☐ Snug
18. Were you wearing a hat or glasses? ☐ Yes ☐ No
19. Does your car have headrests? ☐ Yes ☐ No
    a. If yes, what was the position of those headrests compared to your head before the accident?
       ☐ Top of headrest even with **bottom** of head
       ☐ Top of headrest even with **top** of head
       ☐ Top of headrest even with **middle** of neck
20. Was your car braking? ☐ Yes ☐ No
21. Was your car moving at the time of the accident? ☐ Yes ☐ No
    a. If yes, how fast would you estimate you were going? _____ mph
22. How fast would you estimate the other car was going? _____ mph
23. Head/Body position at the time of impact:
    ☐ Head turned left/right ☐ Body straight in sitting position
    ☐ Head looking back ☐ Body rotated right/left
    ☐ Head straight forward ☐
24. As a result of the accident you were: ☐ Rendered Unconscious ☐ In Shock
    ☐ Dazed, circumstances vague ☐ Other: _____

25. Could you move all parts of your body? ☐ Yes ☐ No
    a. If no, what parts couldn't you move and why? _____
    _____
26. Where you able to get out of the car and walk unaided? ☐ Yes ☐ No
    a. If no, why not? _____
27. Did you get any bleeding cuts? ☐ Yes ☐ No
28. Did you get any bruises? ☐ Yes ☐ No
29. Please describe how you felt:
    a. Immediately after the accident: _____
    b. Later that day: _____
    c. The next day: _____
30. Check symptoms apparent since the accident:

☐ Headache	☐ Neck Pain/Stiffness	☐ Mid Back Pain
☐ Eyes Light Sensitive	☐ Pain Behind Eyes	☐ Dizziness
☐ Fainting	☐ Sleeping Problems	☐ Numbness in Fingers
☐ Numbness in Toes	☐ Loss of Smell	☐ Loss of Taste
☐ Loss of Memory	☐ Fatigue	☐ Breath Shortness
☐ Irritability	☐ Depression	☐ Ringing/Buzzing
☐ Loss of Balance	☐ Tension	☐ Cold Hands
☐ Cold Feet	☐ Diarrhea	☐ Constipation
☐ Chest Pain	☐ Nervousness	☐ Cold Sweats
☐ Anxious	☐ Facial Pain	☐ Clicking or Popping Jaw
☐ Low Back Pain	☐ Other: _____	

    _____
31. Occupation: _____
32. Employer: _____
33. Have you missed time from work? ☐ Yes ☐ No
    a. If yes, full time off work: _____ to _____
    b. If yes, part time off work: _____ to _____
34. Did you seek medical help immediately after the accident? ☐ Yes ☐ No
    a. If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone else drove me
    ☐ Drove own car ☐ Other: _____
35. Doctor #1:
    a. Name: _____
    b. First Visit Date: _____
    c. Where you examined? ☐ Yes ☐ No
    d. Were X-rays taken? ☐ Yes ☐ No
    e. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
        i. If yes, what kind of treatment did you receive? _____
    f. What benefits did you receive from treatment? _____
    g. Date of last treatment: _____
36. Doctor #2:
    a. Name: _____
    b. First Visit Date: _____
    c. Where you examined? ☐ Yes ☐ No
    d. Were X-rays taken? ☐ Yes ☐ No
    e. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars

i. If yes, what kind of treatment did you receive? _____

f. What benefits did you receive from treatment? _____

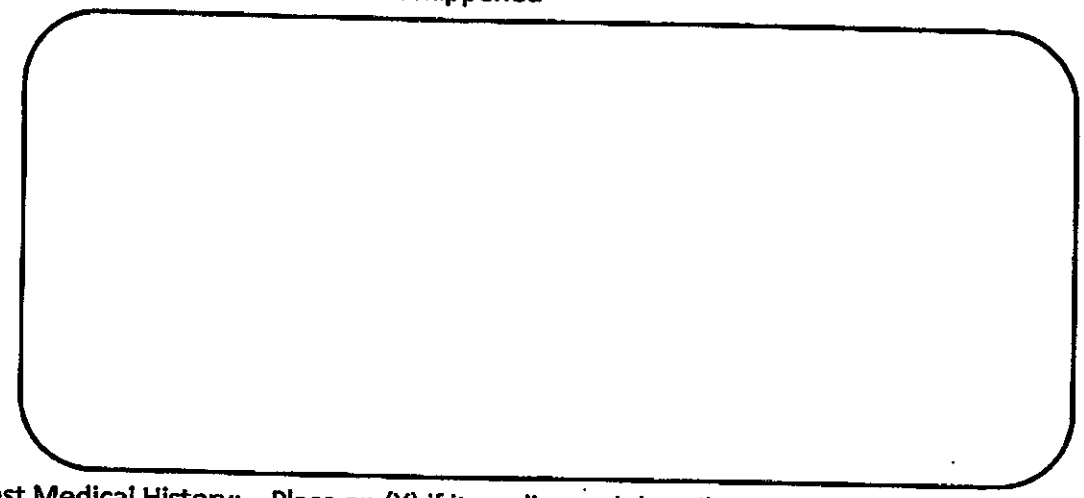
g. Date of last treatment: _____

37. Do you have an attorney on this claim? ☐ Yes ☐ No

a. If yes, who? _____

b. Address: _____

Illustrate below how the accident happened



Past Medical History: Place an (X) if it applies and describe.

☐ None related to current complaints ☐ Hospital / Operation

☐ Auto Accident ☐ Work Accident ☐ Illness ☐ Other

Describe: _____

_____

_____

_____

_____

_____

Family History: Place an (X) if any family member has suffered from:

☐ Tuberculosis	☐ Kidney Disease	☐ Spinal Disorder
☐ Mental Illness	☐ Epilepsy	☐ Diabetes
☐ Gout	☐ Allergy	☐ Arthritis
☐ Hypertension	☐ Cancer	☐ Migraines
☐ Heart Attack	☐ Other, list: _____	

Personal History: Place an (X) if it applies, describe:

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widow/er

Spouses Name: _____ Employed? ☐ Yes ☐ No

Number of Children: _____ Number of Children at Home: _____

Are you pregnant? ☐ Yes ☐ No ☐ Not Sure

Medications, describe: _____

_____

Disease, describe: _____

_____

Other, describe: _____

_____

SYSTEM REVIEW Place an (X) next to the symptoms you know you have

Genito-Urinary System

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

Gastro-Intestinal System

☐ Poor appetite ☐ Excessive hunger ☐ Difficult chewing
☐ Difficult swallowing ☐ Excessive thirst ☐ Nausea
☐ Vomiting food ☐ Abdominal pain ☐ Diarrhea
☐ Constipation ☐ Black stool ☐ Bloody stool
☐ Hemorrhoids ☐ Liver trouble ☐ Gall bladder trouble
☐ Weight trouble

Nervous System

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

Cardio-Vascular System

☐ Chest pain ☐ Pain over heart ☐ Difficult breathing
☐ Persistent cough ☐ Coughing phlegm ☐ Coughing blood
☐ Rapid heartbeat ☐ High blood pressure ☐ Heart problems
☐ Lung problems ☐ Varicose veins ☐ Other

Eye, Ear, Nose and Throat System

☐ Eye strain ☐ Eye inflammation ☐ Vision problems
☐ Ear pain ☐ Ear noises ☐ Ear discharge
☐ Hearing loss ☐ Nose pain ☐ Nose bleeding
☐ Nose discharge ☐ Breathing difficulty ☐ Sore gums
☐ Sore mouth ☐ Sore throat ☐ Hoarseness
☐ Speech difficulty ☐ Dental problems

Activities of Daily Living Assessment

Directions: This questionnaire has been designed to give the doctor information as to how your pain affected your ability to manage in everyday life. Please check one item in each section which most closely applies to you.

SECTION 1 : PAIN INTENSITY

☐ I can tolerate the pain I have without using painkillers.
☐ The pain is bad but I manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers give no relief from pain.

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, 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 manage if they are conveniently positioned (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 very light weights.

☐ I cannot lift or carry anything at all.

SECTION 4 : WALKING

☐ Pain does not prevent me from walking any distance.

☐ Pain prevents me from walking more than one 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 crutches.

☐ I am in bed most of the time and have to crawl to the toilet.

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 for more than one 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.

SECTION 6 : STANDING

☐ I can stand as long as I want without extra pain.

☐ I can stand as long as I want but it causes extra pain.

☐ Pain prevents me from standing for more than one 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.

SECTION 7 : SLEEPING

☐ Pain does not prevent me from sleeping well.

☐ I can sleep well only by using tablets.

☐ Even when I take tablets I have less than 6 hours sleep.

☐ Even when I take tablets I have less than 4 hours sleep.

☐ Even when I take tablets I have less than 2 hours sleep.

☐ Pain prevents me from sleeping at all.

SECTION 8 : SEX LIFE

☐ My sex life is normal and causes no extra pain.

☐ My sex life is normal but causes some extra pain.

☐ My sex life is nearly 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.

SECTION 9 : SOCIAL LIFE

☐ My social life is normal and gives me no extra 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. (dancing, etc.)

☐ Pain has restricted my social life and I do not go out as often.

☐ Pain has restricted my social life to my home.

☐ I have no social life because of pain.

SECTION 10 : TRAVELING

☐ I can travel anywhere without extra pain.

☐ I can travel anywhere but it gives me extra pain.

☐ Pain is bad but I manage journeys over 2 hours.

☐ Pain restricts me to the journeys of less than one hour.

☐ Pain restricts me to short necessary trips under a ½ hour.

☐ Pain restricts me from traveling except to the doctor or hospital.

Current Chief Complaint(s): Place an (X) in the appropriate complaint areas.

SPINE

☐ Low back	☐ Mid back	☐ Neck
☐ Pelvis		

UPPER EXTREMITY

☐ Shoulder R/L	☐ Arm R/L	☐ Elbow R/L
☐ Wrist R/L	☐ Forearm R/L	☐ Hand R/L

LOWER EXTREMITY

☐ Hip R/L	☐ Thigh R/L	☐ Knee R/L
☐ Leg R/L	☐ Ankle R/L	☐ Foot R/L

OTHER (describe): _____

_____

_____

Subjective Pain Level: On a scale of 1-10 place an (X) in your current pain level.

NORMAL

☐ 0

LOW PAIN

☐ 1 ☐ 2 ☐ 3

MODERATE PAIN

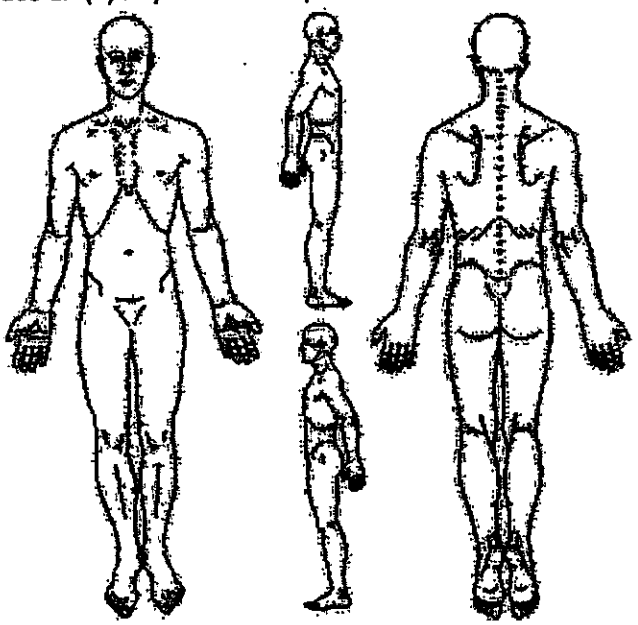
☐ 4 ☐ 5 ☐ 6

INTENSE PAIN

☐ 7 ☐ 8 ☐ 9

EMERGENCY

☐ 10



Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.

X NUMBNESS + BURNING

o PINS & NEEDLES = STABBING

_____

Patient's Signature