

## Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

<b>1. Your vehicle type</b> <input type="checkbox"/> Car <input type="checkbox"/> Station Wagon <input type="checkbox"/> Van <input type="checkbox"/> Pickup Truck <input type="checkbox"/> Large Truck <input type="checkbox"/> Bus <input type="checkbox"/> Other _____	<b>2. Your position in vehicle</b> <input type="checkbox"/> Driver <input type="checkbox"/> Front Passenger <input type="checkbox"/> Left Rear Passenger <input type="checkbox"/> Right Rear Passenger <input type="checkbox"/> Other _____	<b>3. What was your vehicle doing at the time of the accident?</b> <input type="checkbox"/> Stopped at intersection <input type="checkbox"/> Stopped in Traffic <input type="checkbox"/> Stopped at light <input type="checkbox"/> Making a right turn <input type="checkbox"/> Making a left turn <input type="checkbox"/> Parking <input type="checkbox"/> Proceeding along <input type="checkbox"/> Slowing down <input type="checkbox"/> Accelerating <input type="checkbox"/> Other _____
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<b>4. Time/Speed/Damage</b> Time of accident _____ Your vehicle's speed: _____ mph Their vehicle's speed: _____ mph Damage to your vehicle <input type="checkbox"/> Mid <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled	<b>5. Details of Accident</b> Visibility at time of accident <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good Who hit who/what <input type="checkbox"/> You hit other vehicle <input type="checkbox"/> Other vehicle hit you You hit...(object) _____	<b>6. Road conditions</b> <input type="checkbox"/> Icy <input type="checkbox"/> Wet <input type="checkbox"/> Sandy <input type="checkbox"/> Dark <input type="checkbox"/> Clean and dry  Point of impact <input type="checkbox"/> Head-On <input type="checkbox"/> Left Front <input type="checkbox"/> Right Front <input type="checkbox"/> Rear-End <input type="checkbox"/> Left Rear <input type="checkbox"/> Right Rear
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<b>7. Body Position, etc.</b> Did you see the accident coming?    Yes <input type="checkbox"/> No <input type="checkbox"/> Were you braced for the impact?    Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a seat belt on?    Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a shoulder harness on?    Yes <input type="checkbox"/> No <input type="checkbox"/>		Does your vehicle have headrests?    Yes <input type="checkbox"/> No <input type="checkbox"/> What was the position of your headrest at the time of impact? <input type="checkbox"/> Even with top of head <input type="checkbox"/> Even with bottom of head <input type="checkbox"/> Middle of neck What was the direction of your head at the time of impact? <input type="checkbox"/> Facing straight forward <input type="checkbox"/> Turned to the right <input type="checkbox"/> Turned to the left
Did driver side airbags deploy?    Yes <input type="checkbox"/> No <input type="checkbox"/> Did passenger side airbags deploy?    Yes <input type="checkbox"/> No <input type="checkbox"/> Did side airbags deploy?    Yes <input type="checkbox"/> No <input type="checkbox"/>		

**8. Additional accident information**  
 In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

<b>9. During the accident</b> Did your body strike the inside of the vehicle?    Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, describe: _____ Did you lose consciousness during the injury?    Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, for how long? _____ Your vehicle's estimated damage? _____ Damage to their vehicle: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled Did police show up at the scene?    Yes <input type="checkbox"/> No <input type="checkbox"/> Was an accident report filled out?    Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>10. After the accident</b> Check off your symptoms right after and a few days following: <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Mid back pain <input type="checkbox"/> Cold hands <input type="checkbox"/> Neck pain <input type="checkbox"/> Nausea <input type="checkbox"/> Low back pain <input type="checkbox"/> Cold feet <input type="checkbox"/> Neck Stiffness <input type="checkbox"/> Confusion <input type="checkbox"/> Nervousness <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Loss of taste <input type="checkbox"/> Depression <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Tension <input type="checkbox"/> Toe numbness <input type="checkbox"/> Anxious <input type="checkbox"/> Loss of smell <input type="checkbox"/> Irritability <input type="checkbox"/> Constipation <input type="checkbox"/> Chest pain <input type="checkbox"/> Pain behind eyes <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleeping Problems Others: _____
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<b>11. Emergency Room?</b> Where did you go after the accident? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Hospital ER <input type="checkbox"/> Private Doctor How did you get there? <input type="checkbox"/> Drove self <input type="checkbox"/> Somebody else <input type="checkbox"/> Ambulance <input type="checkbox"/> Police Where X-rays done?    Yes <input type="checkbox"/> No <input type="checkbox"/> Was lab work done?    Yes <input type="checkbox"/> No <input type="checkbox"/> Body parts X-rayed? _____ What lab work? _____ The X-Rays revealed? _____ Treatments? <input type="checkbox"/> Cervical Collar <input type="checkbox"/> Ice    Other: _____ Medications: _____ Follow-up instructions: _____ _____	<b>12. Treatment History:</b> Fill in any other doctor(s) seen prior to your first visit to this office. 1. Dr. _____ First visit date: ____/____/____ Specialty: _____ X-rays done?    Yes <input type="checkbox"/> No <input type="checkbox"/> Types of treatments received? _____ Did treatments benefit you?    Yes <input type="checkbox"/> No <input type="checkbox"/> Last visit date: ____/____/____ 2. Dr. _____ First visit date: ____/____/____ Specialty: _____ X-rays done?    Yes <input type="checkbox"/> No <input type="checkbox"/> Types of treatments received? _____ Did treatments benefit you?    Yes <input type="checkbox"/> No <input type="checkbox"/> Last visit date: ____/____/____
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# Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

I. First Current Symptom: (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section.)

<p><b>1. Check only one body location below</b></p> <input type="checkbox"/> Headaches <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head  <input type="checkbox"/> Jaw <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Eye <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Neck <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Upper Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Mid Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Low Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Chest <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Abdomen <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Ribs <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Buttocks <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Upper Arm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Forearm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Lip <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Leg <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Other _____	<p><b>2. Types of Pain</b></p> <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting	<p>Other types of pain: _____</p>																																																																
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<p><b>4. Pain intensity</b> (How it affects your daily activities)</p> <input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects <input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities																																																																		
<p><b>5. Does this pain radiate into other body parts?</b></p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Left</th> <th style="text-align: center;">Right</th> <th style="text-align: center;">Both</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Head</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Neck</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Shoulder</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Arm</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hand</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hip</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Leg</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Foot</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table> <p>Other locations of radiation: _____</p>			Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																													
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II. Second Current Symptom: (Please check off the boxes below to describe your next symptom).

<p><b>1. Check only one body location below</b></p> <input type="checkbox"/> Headaches <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head  <input type="checkbox"/> Jaw <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Eye <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Neck <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Upper Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Mid Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Low Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Chest <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Abdomen <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Ribs <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Buttocks <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Upper Arm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Forearm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Lip <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Leg <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Other _____	<p><b>2. Types of Pain</b></p> <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting	<p>Other types of pain: _____</p>																																																																
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III. Third Current Symptom: (Please check off the boxes below to describe your 3rd symptom).

<p><b>1. Check only one body location below</b></p> <input type="checkbox"/> Headaches <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head  <input type="checkbox"/> Jaw <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Eye <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Neck <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Upper Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Mid Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Low Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Chest <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Abdomen <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Ribs <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Buttocks <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Upper Arm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Forearm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Lip <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Leg <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Other _____	<p><b>2. Types of Pain</b></p> <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting	<p>Other types of pain: _____</p>																																																																
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## Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most describes your current degree of difficulty: **1** = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it at all, because of the pain. **NOTE: Only fill in areas that are affected.**

### Difficulties with Self Care and Personal Hygiene Activities

Bathing .....	Drying hair .....	Brushing teeth .....	Putting on shoes .....	Preparing meals .....	Leaning back .....
Showering .....	Combing hair .....	Making bed .....	Tying shoes .....	Eating .....	Doing laundry .....
Washing hair .....	Washing face .....	Putting on shirt .....	Putting on pants .....	Cleaning dishes .....	Going to toilet .....

### Difficulties with Physical Activities

Standing .....	Walking .....	Kneeling .....	Bending back .....	Twisting left .....	Leaning back .....
Sitting .....	Stooping .....	Reaching .....	Bending left .....	Twisting right .....	Leaning left .....
Reclining .....	Squatting .....	Bending forward .....	Bending right .....	Leaning forward .....	Leaning right .....
Standing for long periods .....	Sitting for long periods .....	Walking for long periods .....	Kneeling for long periods .....		

### Difficulties with Functional Activities

Carrying small objects .....	Lifting weights off floor .....	Pushing things while seated .....	Exercising upper body .....
Carrying large objects .....	Lifting weight off table .....	Pushing things while standing .....	Exercising lower body .....
Carrying briefcase .....	Climbing stairs .....	Pulling things while seated .....	Exercising arms .....
Carrying large purse .....	Climbing inclines .....	Pulling things while standing .....	Exercising legs .....

### Difficulties with Social and Recreational Activities

Bowling .....	Jogging .....	Swimming .....	Ice Skating .....	Competitive Sports .....	Dating .....
Golfing .....	Dancing .....	Skiing .....	Roller Skating .....	Hobbies .....	Dining Out .....

### Difficulties with Traveling

Driving a motor vehicle .....	Riding as a passenger in a motor vehicle .....	Riding as a passenger on a train .....
Driving for long periods of time .....	Riding as a passenger in an airplane .....	Riding as a passenger for long periods .....

Use the following **1 to 5** scale to describe the difficulties below:

**1** = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = "My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

### Difficulties with Different Forms of Communication

Concentrating ..... Hearing ..... Listening ..... Speaking ..... Reading ..... Writing ..... Using keyboard .....

### Difficulties with the senses

Seeing ..... Hearing ..... Sense of touch ..... Sense of taste ..... Sense of smell .....

### Difficulties with Hand Functions

Grasping ..... Holding ..... Pinching ..... Percussive movements ..... Sensory Discrimination .....

### Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep ..... Being able to participate in desired sexual activity .....

**Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above)**

### Prior Symptom History

#### Prior Similar Symptoms

- I have NOT had prior symptoms to my current complaints
- My current complaints DID exist before, but have not been bothering me.
- My current complaints ALREADY existed and were worsened.

#### Has your History Contributed to your Current Symptoms?

- My history HAS contributed to my current symptoms.
- My history HAS NOT contributed to my current symptoms.
- I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior symptoms (if applicable) occurred.....  months ago /  years ago Or on Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Write in below any other Prior Symptom History, not covered above:**