AUTOMOBILE ACCIDENT FORM

PLEASE, ANSWER ALL QUESTIONS COMPLETELY

PATIENT NAME_____ **TODAY'S DATE**_____/_____/_____

DATE OF ACCIDENT _____/_____/_____ TIME OF ACCIDENT _____ □AM _____ □PM

PLEASE, EXPLAINED IN DETAIL HOW YOUR ACCIDENT HAPPENED_____

_____

YOUR VEHICLE TYPE: □CAR □S.U.V. □VAN □TRUCK □OTHER TYPE YEAR, MAKE & MODEL:_____

YOUR POSITION IN VEHICLE: □DRIVER □FRONT PASSENGER □LEFT REAR PASSENGER □RIGHT REAR PASSENGER

OTHER POSITION_____ NUMBER OF PEOPLE IN YOUR VEHICLE: _____

COLLISION TYPE: □HEAD-ON □REAR-END □SIDE CRASH □LEFT FRONT □RIGHT FRONT □LEFT REAR □RIGHT REAR

□SINGLE VEHICLE □THREE-OR-MORE VEHICLES □ROLLOVER □RAN OFF THE ROAD □OTHER_____

DURING THE ACCIDENT:

DID YOU SEE THE ACCIDENT COMING? □YES □NO WERE YOU BRACED FOR IMPACT? □YES □NO

DID YOU HAVE A SEAT BELT ON? □YES □NO DID ANY AIRBAG DEPLOY? □YES □NO

WERE YOU KNOCKED UNCONSCIOUS? □YES □NO IF SO, FOR HOW LONG? _____

DID YOUR HEAD/BODY PART STRIKE ANY PART OF YOUR CAR? □YES □NO EXPLAIN_____

WHAT WAS THE DIRECTION OF YOUR HEAD AT THE TIME OF IMPACT? □FORWARD □TURNED RIGHT □TURNED LEFT

WHERE WERE YOUR HANDS? □BOTH ON THE STEERING WHEEL □RIGHT/LEFT HAND ON STEERING WHEEL

HEAD RESTRAINT POSITION: □EVEN WITH MID NECK □EVEN WITH TOP OF HEAD □EVEN WITH BOTTOM OF HEAD

WHO HIT WHO/WHAT: □YOU HIT OTHER VEHICLE □OTHER VEHICLE HIT YOU □OTHER_____

WHAT WAS YOUR VEHICLE DOING AT TIME OF COLLISION:

□STOPPED □MOVING ALONG □MAKING RIGHT/LEFT TURN □SLOWING DOWN □ACCELERATING

HOW WAS THE VISIBILITY AT THE TIME? □GOOD □FAIR □POOR

HOW WAS THE ROAD CONDITION: □CLEAN & DRY □WET □SANDY □ICY

AFTER THE ACCIDENT:

DID THE POLICE COME TO THE SITE? □YES □NO WAS A POLICE REPORT FILED? □YES □NO

WHERE DID YOU GO AFTER THE ACCIDENT? □HOSPITAL ER □PRIVATE DOCTOR □HOME □WORK

WHEN DID YOU GO? □IMMEDIATELY AFTER ACCIDENT □LATER THAT DAY □NEXT DAY □ OTHER_____

HOW DID YOU GET THERE? □AMBULANCE □DROVE SELF □POLICE □SOMEBODY ELSE_____

IF SO, GIVE HOSPITAL'S NAME OR ATTENDING DOCTOR:_____

WHAT TREATMENT WAS GIVEN?_____WERE X-RAYS TAKEN? □YES □NO

DID YOU FEEL PAIN IMMEDIATELY AFTER THE ACCIDENT? □YES □NO □LATER THAT DAY □NEXT DAY □ _____

WHERE DID YOU FEEL PAIN AFTER THE ACCIDENT?_____

HAVE YOU EVER HAD ANY COMPLAINTS IN THE INVOLVED AREA BEFORE? □YES □NO

HAVE YOU BEEN ABLE TO WORK SINCE THIS INJURY: □YES □NO

ARE YOUR WORK ACTIVITIES RESTRICTED AS A RESULT OF THIS ACCIDENT? □YES □NO

SINCE THE INJURY, ARE YOUR SYMPTOMS GETTING WORSE: □YES □NO □ CONSTANT □COMES & GOES

-INDICATE THE SYMPTOMS THAT ARE RESULT OF THIS ACCIDENT: (USE A CHECK MARK √)

□ DIZZINESS	□ DIFFICULTY SLEEPING	□ NECK STIFFNESS	□ NECK PAIN
□ NAUSEA	□ IRRITABILITY	□ JAW PROBLEMS	□ MID BACK PAIN
□ HEADACHE/S	□ FATIGUE	□ NUMB HANDS/FINGERS	□ LOWER BACK PAIN
□ BLURRED VISION	□ TENSION	□ NUMB FEET/TOES	□ ARMS/SHOULDER PAIN
□ BUZZING IN EAR	□ MEMORY LOSS	□ SHORTNESS OF BREATH	□ LEG/KNEE PAIN
□ EARS RINGING	□ DEPRESSION	□ STOMACH UPSET	□ CHEST PAIN

□OTHERS_____

-INDICATE DEGREE OF COMFORT WHILE PERFORMING THE FOLLOWING ACTIVITIES:

	WALKING	BENDING	LIFTING	RUNNING	SITTING	STANDING	WORKING	LYING DOWN
COMFORTABLE								
UNCOMFORTABLE								
PAINFUL								

DAMAGE TO VEHICLE: □MILD □MODERATE □SEVERE YOUR VEHICLE'S ESTIMATED DAMAGE: $_____

ATTORNEY: HAVE YOU RETAINED AN ATTORNEY? □YES □NO □NOT YET

IF SO, NAME_____ PHONE #: _____

PATIENT SIGNATURE_____**DATE**_____

Vida Chiropractic Center

Neck Pain Disability Index

Please Read: This questionnaire is designed to enable us to understand how much your neck pain is affected your ability to manage everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel more than one statement may relate to you, but please just circle the one choice which 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 comes and goes and is moderate
D. The pain is moderate and doesn't vary much
E. The pain is severe but comes and goes
F. The pain is severe and doesn't vary much

Section 2 – Personal care (washing dressing)

A. I can look after myself 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 have to do it 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 don't get dressed. I wash with difficulty and stay in bed

Section 3 – Lifting

A. I can lift heavy weight without extra pain
B. I can lift heavy weight but it causes pain
C. Pain prevents me from lifting heavy weight
D. Pain prevents me from lifting heavy weight but I can manage to do it if they are conveniently positioned
E. I can lift very light weights
F. I cannot lift or carry anything at all

Section 4 – Reading

A. I can read as much as I want with no neck pain
B. I can read as much as I want with slight neck pain
C. I can read as much as I want with moderate neck pain
D. I cannot read as much as I want because of moderate pain in my neck
E. I cannot read as much as I want because of severe pain in my neck
F. I cannot read at all

Section 5 – Headache

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

Section 6 – Concentration

A. I can concentrate fully with no difficulty
B. I can concentrate fully with slight
C. I have some difficulty in concentrating
D. I have a lot of difficulty concentrating
E. I have a great deal of difficulty concentrating
F. I cannot concentrate at all

Section 7 – Work

A. I can do as much work as I want to
B. I can only do my usual work
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 cannot do any work at all

Section 8 – Driving

A. I can drive my car with no neck pain
B. I can drive as long as I want with slight neck pain
C. I can drive as long as I want with moderate neck pain
D. I cannot drive as long as I want because of moderate neck pain
E. I can hardly drive because of severe neck pain
F. I cannot drive at all

Section 9 – Sleeping

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

Section 10 – Recreation

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

Signature_____

Date_____ Disability Index Score_____%

Vida Chiropractic Center

Low Back Disability Index

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

Section 1 – Pain intensity

A. The pain comes and goes and is mild
B. The pain is mild and doesn't vary much
C. The pain comes and goes and is moderate
D. The pain is moderate but doesn't vary much
E. The pain is severe but comes and goes
F. The pain is severe and doesn't vary much

Section 2 – Personal care (washing/dressing)

A. I don't have to change the way of washing/ dressing in order to avoid pain
B. I don't change the way of washing/dressing even though it causes some pain
C. Washing/dressing increases the pain but I can manage
D. Washing/dressing increases the pain and I have to change my way of doing it.
E. Because of pain I'm unable to do most washing/dressing without help
F. Because of pain I'm unable to do any washing/dressing without help

Section 3 – Lifting

A. I can lift heavy weight without extra pain
B. I can lift heavy weight but it causes pain
C. Pain prevents me from lifting heavy weight
D. Pain prevents me from lifting heavy weight but I can manage to do it if they are conveniently positioned
E. I can lift very light weights
F. I cannot lift or carry anything at all

Section 4 – Walking

A. Pain doesn't prevent me from walking any distance
B. I have some pain while walking but doesn't increase
C. Pain prevents me from walking one mile
D. Pain prevents me from walking more than ½ mile
E. I can only walk while using a cane or crutches
F. I am in bed most of the time, I can't walk without help

Section 5 – Sitting

A. I can sit as long as I want without pain
B. I can only sit on comfortable chair as long as I want
C. Pain prevents me from sitting for more than an 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 want with no pain
B. I have some pain while standing but doesn't increase
C. I can't stand longer than 1 hour without increasing pain
D. I can't stand longer than ½ without increasing pain
E. I can't stand longer than 10 minutes without increasing pain
F. I avoid standing because it increases pain right away

Section 7 – Sleeping

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

Section 8 – Social life

A. My social life is normal and causes no pain
B. My social life is normal but increases pain
C. Pain has some effect on my social life
D. Pain has restricted my social life and I don't go out much
E. Pain has restricted my social life to my home
F. Pain prevents me from having a social life at all

Section 9 – Traveling

A. I get no pain while traveling
B. I get some pain while traveling but doesn't affect my traveling
C. I get extra pain while traveling but doesn't make me seek alternative forms of traveling
D. I get extra pain while traveling and makes me seek alternative ways of traveling
E. Pain restricts all forms of travel
F. I can only travel if I am laying down

Section 10 – Degree of pain

A. My pain is rapidly getting better
B. My pain fluctuates but is getting better
C. My pain is getting better but improvement is slow
D. My pain is neither getting better nor worse
E. My pain is gradually getting worse
F. My pain is rapidly getting worse

Signature_____ Date_____ Disability Index Score_____

Duties Performed Under Duress at Work and Home

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all that apply to your WORK *because of the accident*.

- ☐ I go to work but work in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the Computer at work hurts
- ☐ Pushing at work hurts
- ☐ Pulling at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ _____
- ☐ _____

- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't used to
- ☐ I hide my poor work performance from my boss
- ☐ _____
- ☐ _____

Please check all that apply to your HOME/DOMESTIC duties *because of the accident*.

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot wash dishes now
- ☐ Vacuuming hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ _____
- ☐ _____

- ☐ I cannot take time off because I care for children
- ☐ I have _____ children ages _____
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the work now
- ☐ Others living with me do my share of the yard work
- ☐ Others living with me do my share of the gardening
- ☐ _____
- ☐ _____

_____ _____

Signature Date

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (p. 1 of 2)

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all that apply to your EXERCISE & SPORTS Activity *because of the accident*.

- ☐ My exercise was affected by this crash
- ☐ I go to the gym & work out in pain
- ☐ I no longer go to the gym to work out
- ☐ I run but in pain
- ☐ I no longer run
- ☐ I take walks & have pain while walkiing
- ☐ I no longer take walks
- ☐ I used to make income at sports
- ☐ I have lost sports income since crash
- ☐ I am an amateur athlete
- ☐ I am a professional athlete
- ☐ _____
- ☐ _____
- ☐ I have gained _____ pounds since the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks

Please check all that apply to your HOBBY Activities *because of the accident*.

- ☐ My hobbies were affected by accident
- ☐ Hobby #1 _____
- ☐ I can't do hobby #1 anymore
- ☐ I do hobby #1 but in pain
- ☐ I have lost money from not doing #1
- ☐ I didn't do hobby #1 for _____ weeks
- ☐ Hobby #2 _____
- ☐ I can't do hobby #2 anymore
- ☐ I do hobby #2 but in pain
- ☐ I have lost money from not doing #2
- ☐ I didn't do hobby #2 for _____ weeks
- ☐ Hobby #3 _____
- ☐ I can't do hobby #3 anymore
- ☐ I do hobby #3 but in pain
- ☐ I have lost money from not doing #3
- ☐ I didn't do hobby #3 for _____ weeks
- ☐ Hobby #4 _____
- ☐ I can't do hobby #4 anymore
- ☐ I do hobby #4 but in pain
- ☐ I have lost money from not doing #4
- ☐ I didn't do hobby #4 for _____ weeks
- ☐ _____

Please check all that apply to your TRAVEL Activities *because of the accident*.

- ☐ Business travel was affected by crash
- ☐ Pleasure travel was affected by crash
- ☐ I hurt driving in my own car
- ☐ I am in too much pain to drive
- ☐ I hurt when a passenger in a car
- ☐ I am in too much pain to sit in a car
- ☐ I have anxiety when I'm in a car
- ☐ I hurt when I'm on an airplane
- ☐ I am in too much pain to travel by plane
- ☐ Travel Plan #1 _____
- ☐ I did not go on travel plan #1
- ☐ I went, but did not enjoy #1 as much
- ☐ I went and the accident had no effect on #1
- ☐ Travel Plan #2 _____
- ☐ I did not go on travel plan #2
- ☐ I went, but did not enjoy #2 as much
- ☐ I went and the accident had no effect on #2
- ☐ I missed time with my family/friends b/c can't travel

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all the DAILY LIVING Activities that cause you pain *because of the accident*.

- ☐ Dressing
- ☐ Putting on pants
- ☐ Putting on shoes
- ☐ Tying my shoes
- ☐ Putting on shirt
- ☐ Drying my hair
- ☐ Combing my hair
- ☐ Washing my hair
- ☐ Taking a shower
- ☐ Taking a bath
- ☐ Leaning forward
- ☐ Laying in bed
- ☐ Sitting in my favorite chair
- ☐ Sleeping
- ☐ Going out with my friends
- ☐ Sitting in a restaurant
- ☐ Shopping
- ☐ Driving to/from work
- ☐ Sitting in Church
- ☐ Playing with my children
- ☐ Caring for my children
- ☐ Bending at the waist
- ☐ Sitting in a movie theater
- ☐ Exercise
- ☐ Eating
- ☐ Stooping
- ☐ Squatting down
- ☐ Kneeling
- ☐ Brushing my teeth
- ☐ Riding in a car
- ☐ Opening a jar
- ☐ Lifting a pan when cooking
- ☐ Closing the trunk on my car
- ☐ Opening the garage door
- ☐ Using my home computer
- ☐ Climbing stairs
- ☐ Going down stairs
- ☐ Sexual activity
- ☐ Turning my head to left or right
- ☐ Holding my head up all day
- ☐ Watching TV
- ☐ I have pain sitting & doing nothing
- ☐ Talking on the phone
- ☐ Reading
- ☐ Writing
- ☐ Opening doors
- ☐ Drying with a towel after a bath or shower
- ☐ Life has become a chore just to do normal things
- ☐ It is depressing to live like this
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Please check all that apply to your SCHOOL & EDUCATION Activities *because of the accident*.

- ☐ School was affected by the accident
- ☐ I am a student at _____
- ☐ I am in the _____ year/grade
- ☐ I was ☐ full time ☐ part time
- ☐ I am now ☐ full time ☐ part time
- ☐ I had to take fewer classes b/c of crash
- ☐ I missed _____ days of school
- ☐ I had to drop out of school b/c of crash
- ☐ My grades are lower since the crash
- ☐ I have pain carrying my school books
- ☐ I hurt sitting in class more than _____ minutes
- ☐ My neck hurts when I look down to read
- ☐ I don't learn as quickly as before the crash
- ☐ I don't learn things as well as before the crash
- ☐ I have difficulty concentrating in class
- ☐ It takes much longer to study/do my homework
- ☐ _____
- ☐ _____

_____ _____

Signature of Patient Date