

PERSONAL INJURY INFORMATION

Name _____	Date _____	Phone _____
Address _____	City _____	State _____ Zip _____
Employer's Name _____	Employer's Address _____	

Your Ins. Co. _____	Address _____	
Phone _____	Accident Claim # _____	Agent's Name _____
Driver/Other Vehicle _____	Ins. Co. _____	Policy # _____
Have you retained an attorney? () Yes () No Name _____		
Were there any witnesses? () Yes () No Name(s) _____		

NATURE OF ACCIDENT

1. Date of Accident _____ Time of Day _____ Road Conditions _____
2. Were you: () Driver () Passenger () Front Seat () Back Seat
3. Number of people in your vehicle _____ Other Vehicle _____
4. What direction were you headed? () North () East () South () West
5. On (name of street) _____
6. What direction was the other vehicle headed () North () East () South () West
7. On (name of street) _____
8. Were you struck from () Behind () Front () Left Side () Right Side
9. Were you knocked unconscious? () Yes () No If yes, for how long? _____
10. Were the police notified? () Yes () No
11. In your own words, please describe the accident: _____

12. Did you have any physical complaints BEFORE THE ACCIDENT? () Yes () No If yes, please describe in detail: _____

13. Do you have any congenital (from birth) factors which relate to this problem? () Yes () No If yes, please describe: _____
14. Do you have any previous illnesses that relate to this case? () Yes () No If yes, please describe: _____

15. Please describe how you felt
- a. DURING the accident: _____
 - b. IMMEDIATELY AFTER the accident: _____
 - c. LATER THAT DAY: _____
 - c. THE NEXT DAY: _____

16. What are your PRESENT complaints and symptoms?

17. Where were you taken after the accident?

18. Have you been treated by another doctor since the accident? () Yes () No If yes, please list the doctor's name and address:

19. What type of treatment did you receive?

20. Do you notice any activity restrictions as a result of this injury? () Yes () No If yes, please describe in detail:

22. Since this injury occurred, are your symptoms: () Improving () Getting worse () Same

23. Have you lost time from work as a result of this accident? () Yes () No If yes, please complete the following question.
Last date worked: _____ Dates you missed work: _____ Type of employment: _____

24. Are you being compensated for time lost from work? () Yes () No If yes, please state type of compensation you are receiving: _____

26. Have you ever been involved in an accident before? () Yes () No If yes, please describe, including date(s) and type(s) of accidents as well as injury(ies) received. _____

27. Where were you taken after the accident(s)? _____

28. Have you been treated by another doctor since the accident(s)? () Yes () No If yes, please list the doctor's name. _____

29. What type of treatment(s) did you receive? _____

Patient Signature _____ Date _____

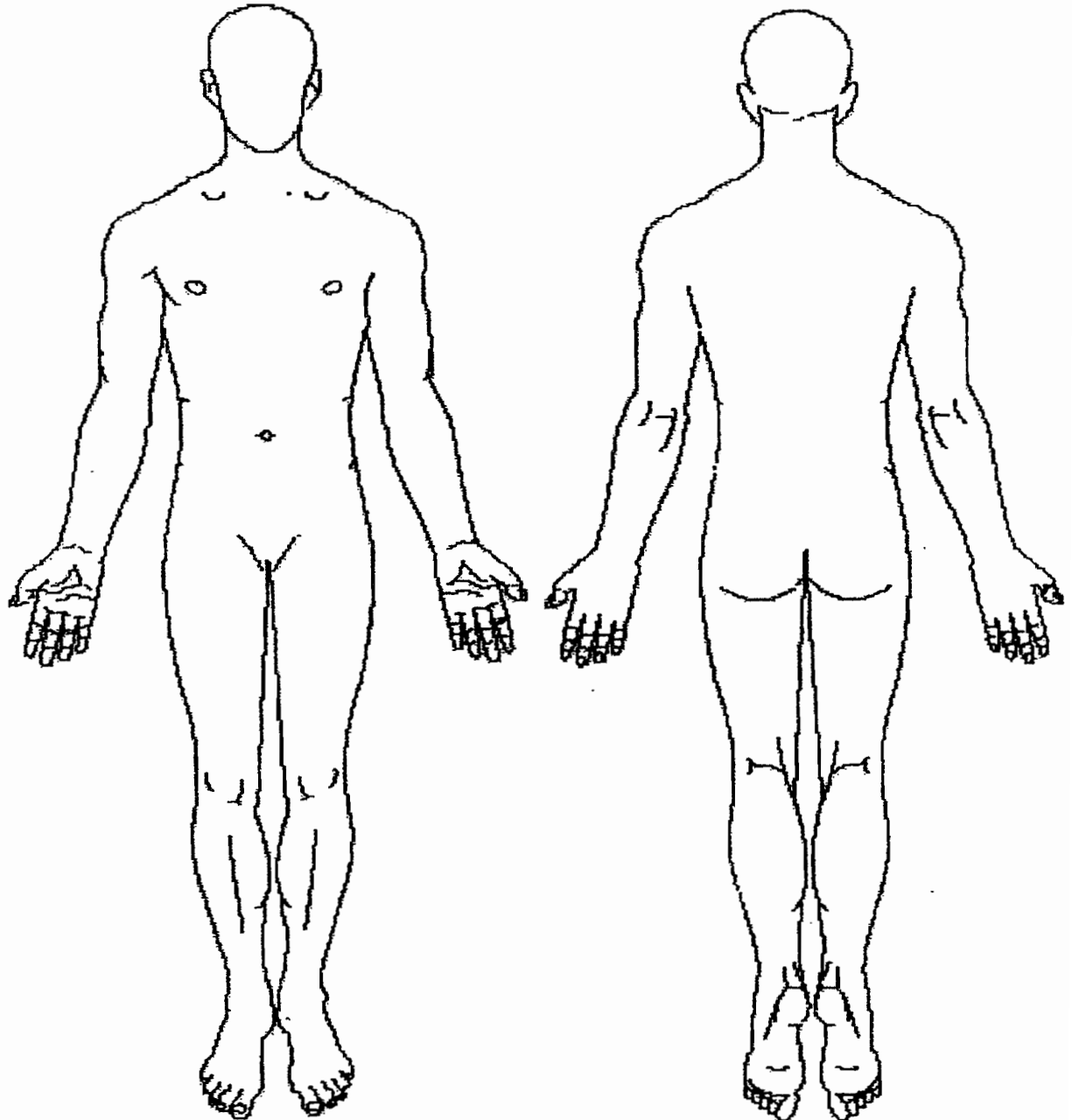
Before Accident
PAIN DRAWING

Patient Name: _____
Attending Dr.: _____

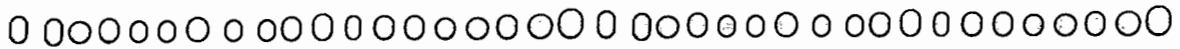
Date: _____

Using the letters below, mark the areas on your body where you feel the described sensations. Include all affected areas. Please complete the picture by drawing your face.

A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing



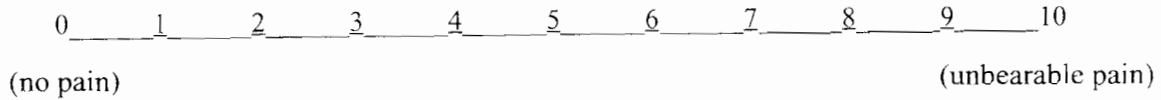
Patient Signature: _____
Date: _____



Before Accident

VISUAL ANALOG SCALE

(Please indicate the pain level you are currently experiencing by writing each involved body area on the scale below)



ACTIVITIES OF DAILY LIVING

People with vertebral subluxation may find that certain activities are restricted or difficult to do. Circle the numbers that correlate to the activities that you find difficult to do because of your condition (there is room to write in others shown below as well):

- | | |
|--|---|
| <ul style="list-style-type: none"> 1. Sleep through the night 2. Get out of bed easily 3. Make your bed 4. Bathe yourself 5. Wash, comb or dry hair 6. Bend over a sink for 10 minutes 7. Go to the bathroom 8. Put socks, shoes or clothing on/take them off 9. Walk up _____ flights of stairs 10. Walk down _____ flights of stairs 11. Turn a door knob 12. Open a heavy door 13. Sit in a chair for _____ minutes before discomfort 14. Sit in a chair for _____ minutes before the need to stretch 15. Get up from a low seat 16. Cross legs for _____ minutes | <ul style="list-style-type: none"> 17. Walk for _____ minutes 18. Stand for _____ minutes 19. Exercise for _____ minutes 20. Travel on a journey that takes over _____ hours 21. Push/pull vacuum cleaner or mower mower 22. Carry items like groceries/child or boxes, etc. 23. Wash the floors, kitchen or bathroom 24. Shovel snow or dirt 25. Bend over to garden 26. Use hand held tools (pencil, hammer, screw driver, etc) 27. Reach in front or overhead to perform a task 28. Enjoy hobbies or social activities |
|--|---|

Circle any of the following conditions you are currently experiencing or are suffering from:

- 1. Neck or back weakness
- 2. Restricted movement of neck or back
- 3. Persistent tender areas in muscles of neck or back
- 4. "Catch" or "kink" in neck or back

Total # ADL items circled: _____

Subjective total: _____

Sign & Date

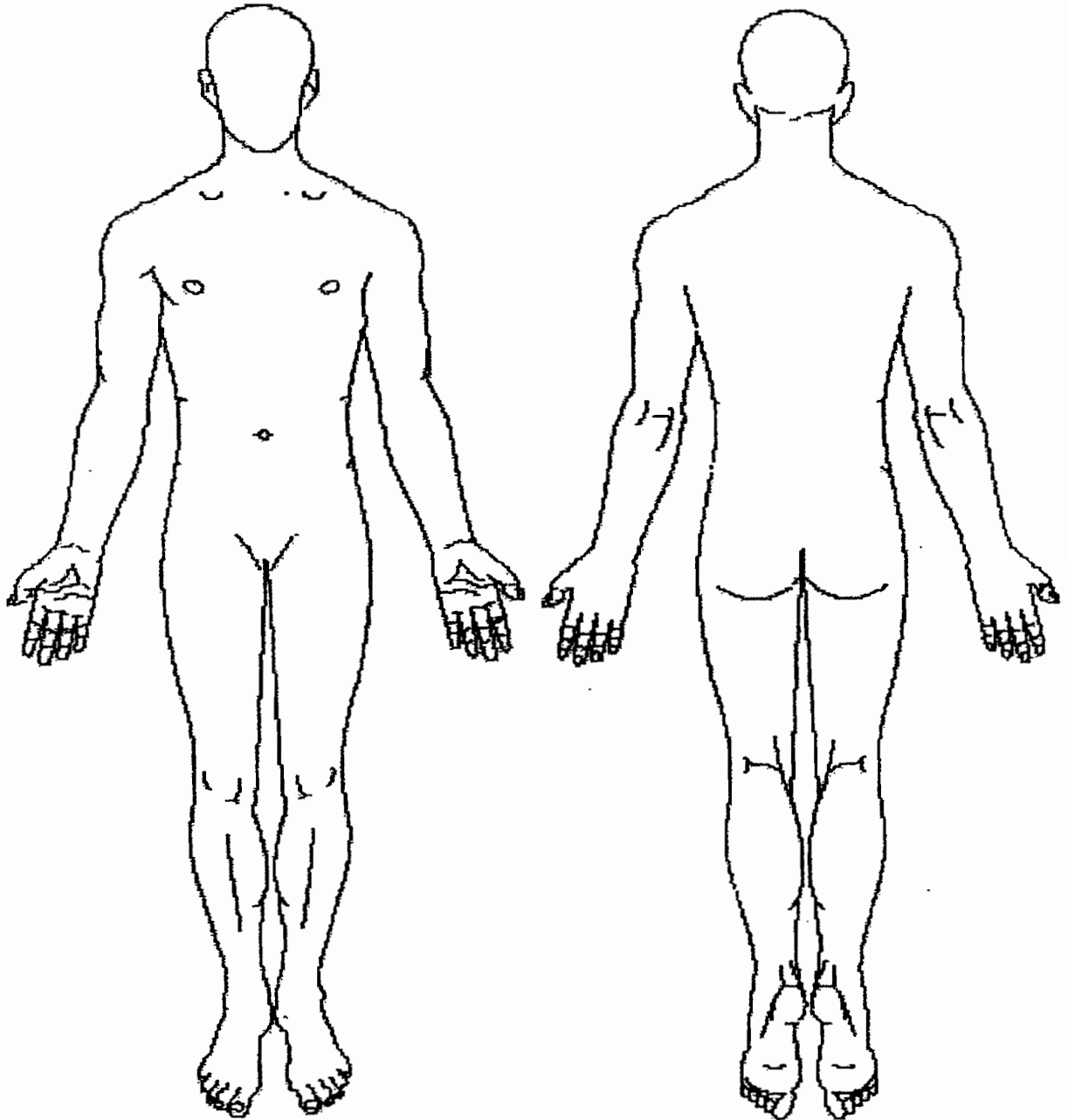
After Accident
PAIN DRAWING

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Attending Dr.: _____

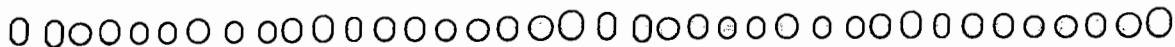
Date: _____

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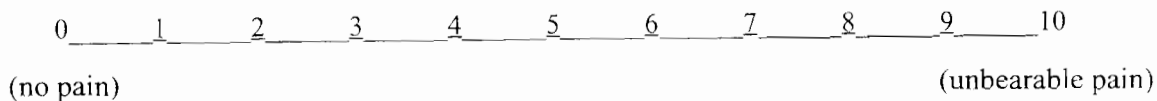
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