Back in Balance
REDMOND

Personal Injury Information

First Name: ______________________ Last Name: ______________________

Date: ______ / ______ / ______ Phone: ______________________

Address: ______________________ State: ______________________

City/Town: ______________________ Zip Code: ______________________

Your Auto Ins. Co ______________________ Driver/Other Vehicle: ______________________

Phone: ______________________ Ins. Co: ______________________

Address: ______________________ Policy #: ______________________

Accident Claim #: ______________________

Agent's Name: ______________________

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 ❑ Passanger ❑ Front Seat ❑ Back seat ❑

3. Number of people in your vehicle: ____________ In the 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: ______________________

____

____

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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:

During the accident: ______________________________

Immediately after the accident: ______________________________

Later that day: ______________________________

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: ______________________________

21. Since this injury occurred, are your symptoms: Improving ❑ Getting worse ❑ Same ❑

22. 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: __________

23. Are you being compensated for time lost from work? Yes ❑ No ❑

If yes, please state type of compensation you are receiving: ______________________________

24. 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: ______________________________

25. Where were you taken after the accident(s)? ______________________________

26. Have you been treated by another doctor since the accident(s)? Yes ❑ No ❑

If yes, please list the doctor's name: ______________________________

27. What type of treatment(s) did you receive? ______________________________

______________________________ ______________

(Patient Signature) *(Date)*

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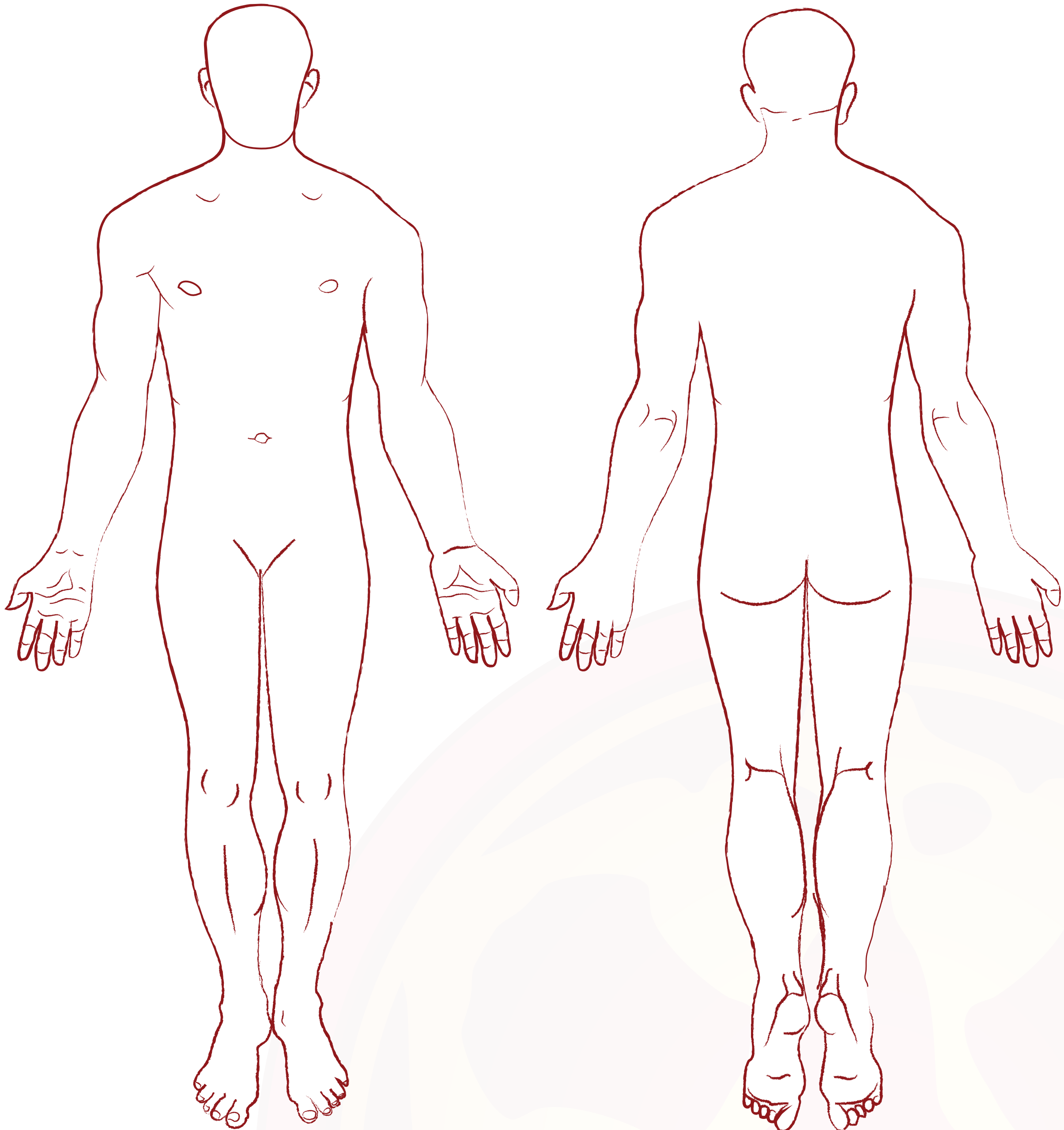
Pain Drawing

Patient Name: ______________________________ Date: ________________

Attending Dr.: ______________________________

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: ________________

SUBJECTIVE and OBJECTIVE NUMERICAL OUTCOME MEASURE ASSESSMENT

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Visual Analog Scale

Patient Name: ______________________________ Date: __________________

Attending Dr.: ______________________________

Please indicate your level of pain on the scale below

(Please circle and label a number for *each* symptom/body part that is causing pain/discomfort/or problems)

0 _______ **1** _______ **2** _______ **3** _______ **4** _______ **5** _______ **6** _______ **7** _______ **8** _______ **9** _______ **10**

No pain ***Unbearable pain***

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.

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. Wash dishes for more than 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 doorknob

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

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

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, screwdriver, etc.)

27. Reach in front or overhead to perform a task

28. Enjoy hobbies or social activities

29. Sit at a desk/use computer for _______ minutes

30. Hold Book/Tablet/Phone for _______ minutes

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

Patient Signature: ____________________

Date: __________________

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Total # ADL items circled: __________

Subjective total: __________

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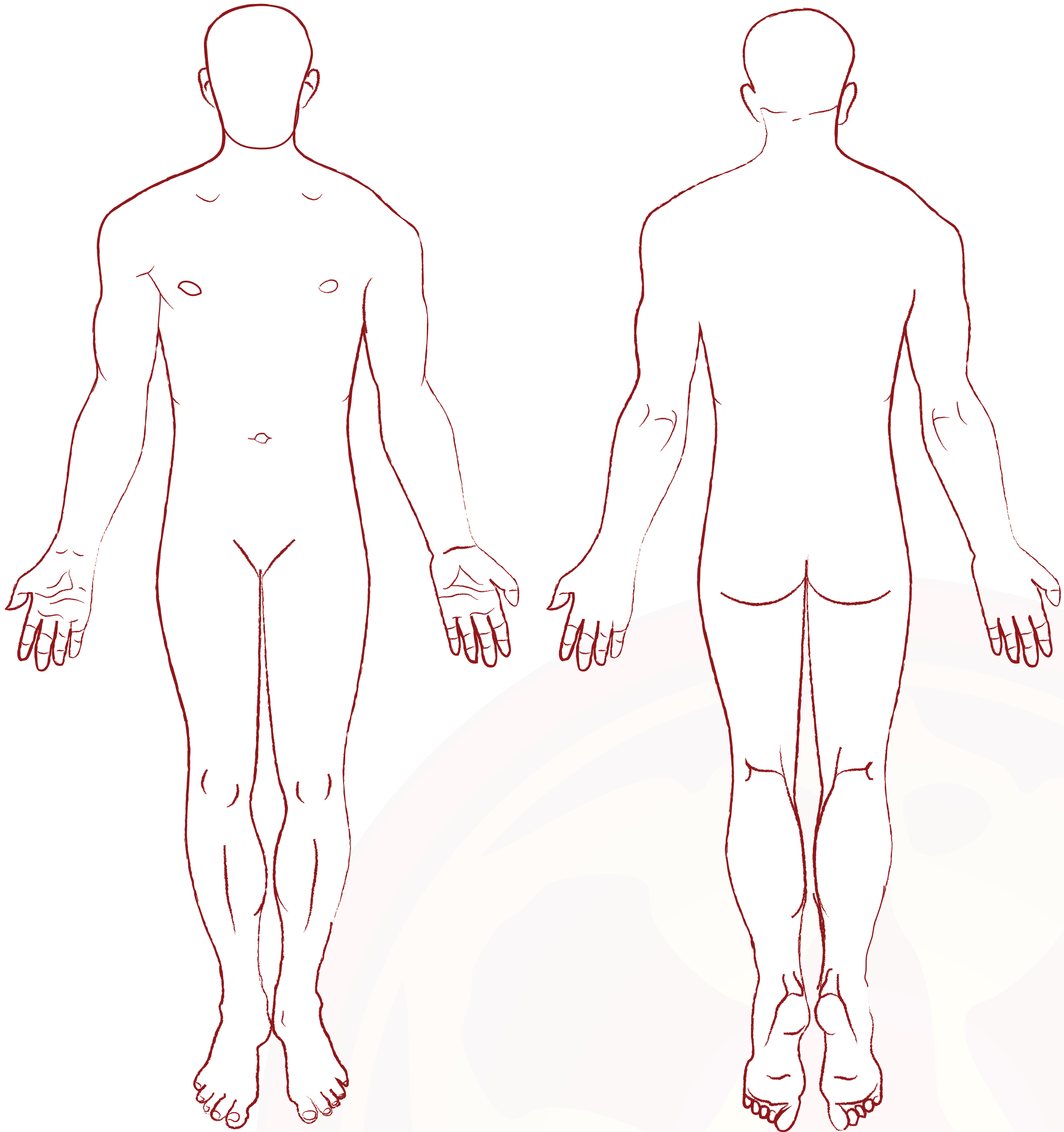

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