Back in Balance
REDMOND

Personal Injury Information

First Name: _____ Last Name: _____

Birth Date: _____ / _____ / _____ *(Month / Day / Year)* 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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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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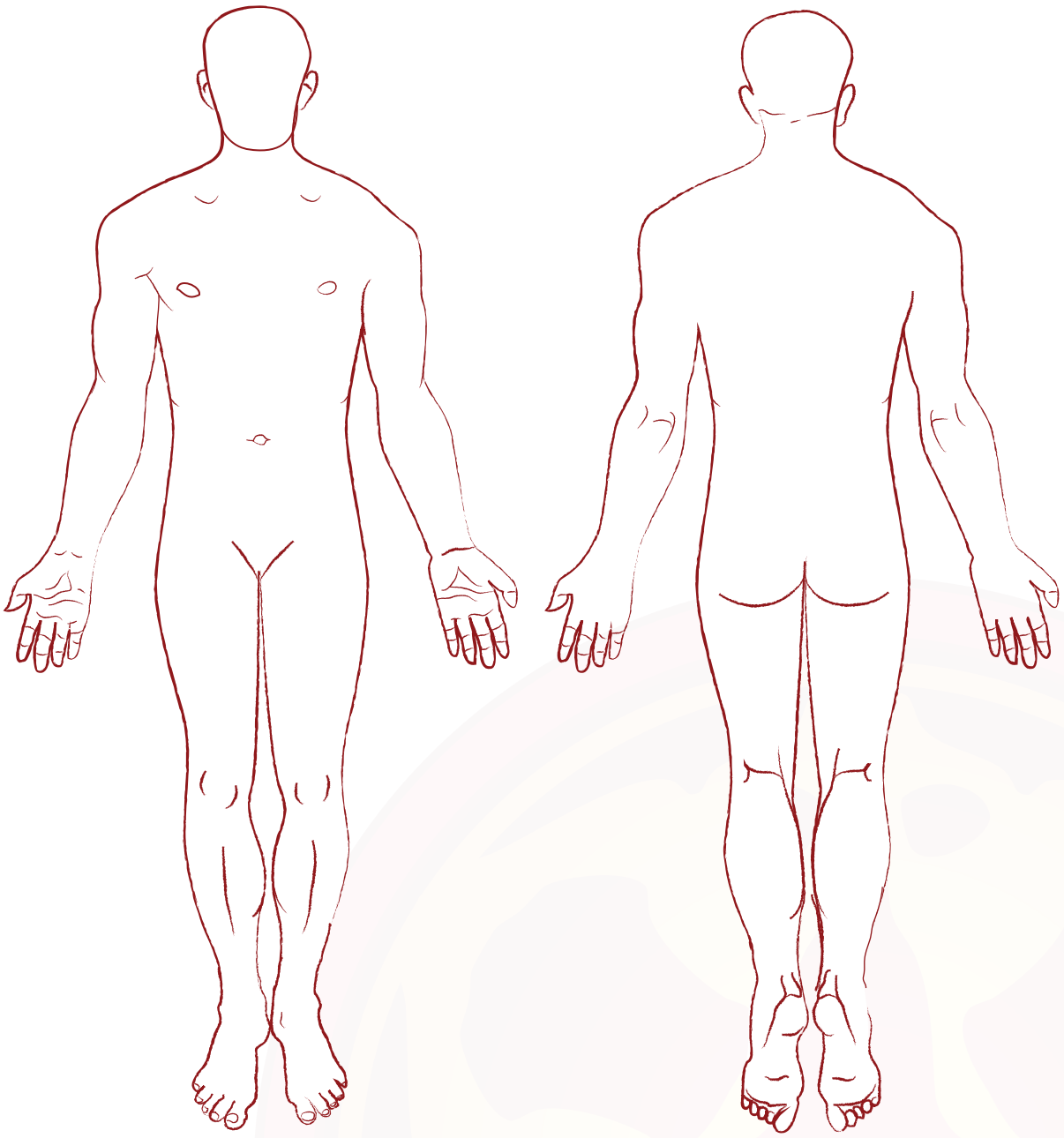
Pain Drawing

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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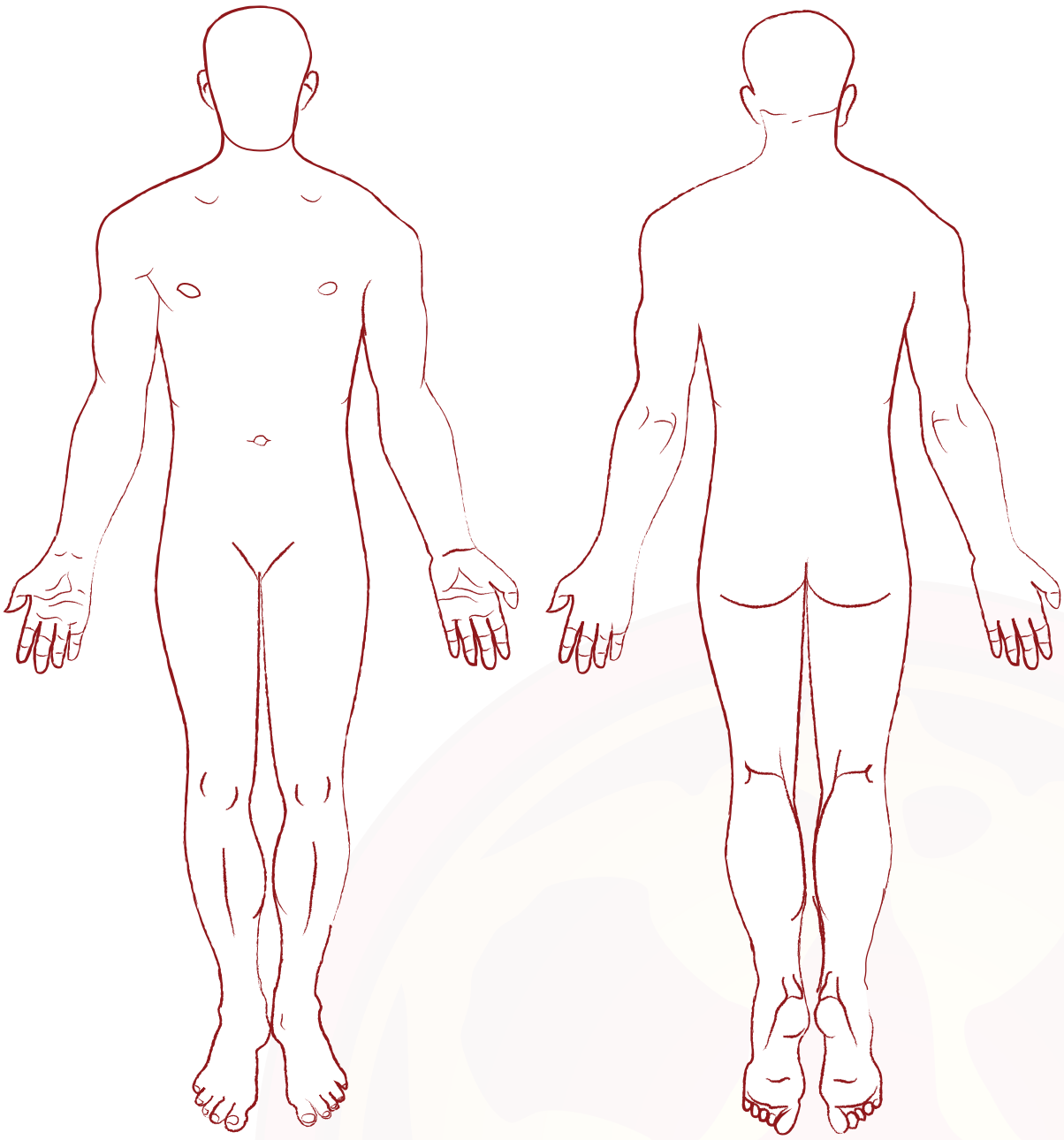
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