AUTOMOBILE ACCIDENT HISTORY FORM

Name: _____ Date: _____

Date of Accident: _____ Time of accident: _____ am/pm

City of Accident: _____ Street of Accident: _____

List the year, make and model of the vehicle you were in: Year: _____ Make: _____ Model: _____

If you know, list the make and model of the other vehicle: Make: _____ Model: _____

Did the police come to the accident scene? YES NO Is there a report? YES NO

Please give your best description of what happened during this accident: _____

_____

_____

_____

_____

_____

Road conditions at the time of the accident: WET DRY ICY OTHER: _____

Where were you seated in the vehicle? _____

Was your car stopped at the time of impact? YES NO

If yes, was the driver's foot also on the brake? YES NO

If no, then estimate the speed of the vehicle you were in: _____ mph

Approx. speed other vehicle: _____ mph

Were you struck from: BEHIND FRONT LEFT RIGHT OTHER:

Was the trunk of your body pointed straight forward at the time of the collision? YES NO;

If no, how was it turned? _____

Was your head pointed straight forward? YES NO If no, what direction was it turned and by how much? _____

On what part of the automobile did your following body parts hit?

Head hit	right/left arm hit	right/left knee hit
Chest hit	right/left hip hit	other
right/left shoulder hit	right/left leg hit	

What bleeding cuts, if any, did you sustain during this accident? _____

What bruises, if any, did you sustain during this accident? _____

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise? AWARE SURPRISED

Did you lose consciousness (black out) upon impact? YES NO If yes, how long:

Do you remember the actual collision? YES NO

Did you experience a flash of light or explosion in your head? YES NO

Circle all that apply: After the accident, I was/had CONFUSED DISORIENTED LIGHT HEADED

DIZZY NAUSEATED BLURRED VISION RINGING/BUZZING IN EARS

If you still have any of those symptoms, which ones? _____

Are you currently suffering from any of the following (please circle):

RESTLESSNESS	DIFFICULT WITH MEMORY	REDUCED TOLERANCE TO HEAT
IRRITABLE	SLEEPLESSNESS	REDUCED TOLERANCE TO ALCOHOL
DIFFICULT CONCENTRATING	FORGETFULNESS	

What is the approximate distance between the back of your head and your vehicle's headrest? _____Inches

Did your head go back over the top of your vehicle's headrest? YES NO

Were you wearing a seatbelt? YES NO If yes, was it a: shoulder-lap seatbelt lap seatbelt

Did you receive any injury or bruise from the seat belt (i.e. breast or abdomen)? YES NO

If YES, then describe: _____

Does your vehicle have an airbag? YES NO Did the airbag deploy in this accident? YES NO

Did you receive an injury from the airbag? YES NO

Please describe: _____

Did you go to a hospital/doctor? YES NO

If yes, what is the name and city of the hospital/facility? _____

How did you get to the hospital? _____

What parts of your body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

What is the estimated cost damage to the vehicle you were in? $_____

Which of the following car parts broke during the accident? (Please circle all that apply):

Windshield Front seat Right/left side window Steering wheel Other:_____

Did you have any physical complaints **before the accident** YES NO

Describe them and rate their pain **before the accident** on a scale 1-10 with 10 being the worst pain you can imagine.

_____

_____

_____

_____

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. _____

_____

_____

_____

_____

Have you been treated by another doctor since this accident? YES NO If yes, please list their name(s) and type of treatment:

_____

_____

_____

_____

Since this NEW injury occurred are your symptoms:

IMPROVING GETTING WORSE THE SAME

If worsening or improving, please describe how:_____

_____

_____

The Neck Disability Index

Patient Name: _____ File #: _____ Date: _____

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1 - PAIN INTENSITY

[ ] I have no pain at the moment.
[ ] The pain is very mild at the moment.
[ ] The pain is moderate at the moment.
[ ] The pain is fairly severe at the moment.
[ ] The pain is very severe at the moment.
[ ] The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE (Washing, Dressing, etc.

[ ] I can look after myself normally, without causing extra pain.
[ ] I can look after myself normally, but it causes extra pain.
[ ] It is painful to look after myself and I am slow and careful.
[ ] I need some help, but manage most of my personal care.
[ ] I need help every day in most aspects of self care.
[ ] I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

[ ] I can lift heavy weights without extra pain.
[ ] I can lift heavy weights, but it gives extra pain.
[ ] Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
[ ] Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
[ ] I can lift very light weights.
[ ] I cannot lift or carry anything at all..

SECTION 4 – READING

[ ] I can read as much as I want to, with no pain in my neck.
[ ] I can read as much as I want to, with slight pain in my neck.
[ ] I can read as much as I want to, with moderate pain in my neck.
[ ] I can't read as much as I want, because of moderate pain in my neck.
[ ] I can hardly read at all, because of severe pain in my neck.
[ ] I cannot read at all.

SECTION 5 – HEADACHES

[ ] I have no headaches at all
[ ] I have slight headaches that come infrequently.
[ ] I have moderate headaches that come infrequently.
[ ] I have moderate headaches that come frequently.
[ ] I have severe headaches that come frequently.
[ ] I have headaches almost all the time.

Score: 56 **%Disability:**_____

[ ] 10-28% Mild [ ] 30-48% Moderate
[ ] 50-68% Severe [ ] 72%or more Complete Dis.

SECTION 6 – CONCENTRATION

[ ] I can concentrate fully when I want to, with no difficulty.
[ ] I can concentrate fully when I want to, with slight difficulty.
[ ] I have a fair degree of difficulty in concentrating when I want to.
[ ] I have a lot of difficulty in concentrating when I want to.
[ ] I have a great deal of difficulty in concentrating when I want to.
[ ] I cannot concentrate at all.

SECTION 7 – WORK

[ ] I can do as much work as I want to.
[ ] I can do my usual work, but no more.
[ ] I can do most of my usual work, but no more.
[ ] I cannot do my usual work.
[ ] I can hardly do any work all.
[ ] I can't do any work at all.

SECTION 8 – DRIVING

[ ] I can drive my car without any neck pain.
[ ] I can drive my car as long as I want, with slight pain in my neck.
[ ] I can drive my car as long as I want, with moderate pain in my neck.
[ ] I can't drive my car as long as I want, because of moderate pain in my neck.
[ ] I can hardly drive at all, because of severe pain in my neck.
[ ] I can't drive my car at all.

SECTION 9 – SLEEPING

[ ] I have no trouble sleeping.
[ ] My sleep is slightly disturbed (less than 1 hr. sleepless)
[ ] My sleep is mildly disturbed (1-2 hrs sleepless).
[ ] My sleep I moderately disturbed (2-3 hrs. sleepless).
[ ] My sleep is greatly disturbed (3-5 hrs. sleepless).
[ ] My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 – RECREATION

[ ] I am able to engage in all my recreation activities, with no neck pain at all.
[ ] I am able to engage in all my recreation activities, with some neck pain at all.
[ ] I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
[ ] I am able to engage in few of my recreation activities, because of pain in my neck.
[ ] I can hardly do any recreation activities, because of pain in my neck.
[ ] I can't do any recreation activities at all.

Patient Signature: _____

Doctor Signature: _____

The Roland – Morris Low Back Pain and Disability Questionnaire

Patient name: _____ File # _____ Date: _____

Please read instructions: when your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

[ ] I stay at home most of the time because of my back.
[ ] I change position frequently to try to get my back comfortable.
[ ] I walk more slowly than usual because of my back.
[ ] Because of my back, I am not doing any jobs that I usually do around the house.
[ ] Because of my back, I use a handrail to get upstairs.
[ ] Because of my back, I lie down to rest more often.
[ ] Because of my back, I have to hold on to something to get out of an easy chair.
[ ] Because of my back, I try to get other people to do things for me.
[ ] I get dressed more slowly than usual because of my back.
[ ] I only stand up for short periods of time because of my back.
[ ] Because of my back, I try not to bend or kneel down.
[ ] I find it difficult to get out of a chair because of my back.
[ ] My back is painful almost all of the time.
[ ] I find it difficult to turn over in bed because of my back.
[ ] My appetite is not very good because of my back.
[ ] I have trouble putting on my sock (or stockings) because of the pain in my back.
[ ] I can only walk short distances because of my back pain.
[ ] I sleep less well because of my back.
[ ] Because of my back pain, I get dressed with the help of someone else.
[ ] I sit down for most of the day because of my back.
[ ] I avoid heavy jobs around the house because of my back.
[ ] Because of back pain, I am more irritable and bad tempered with people than usual.
[ ] Because of my back, I go upstairs more slowly than usual.
[ ] I stay in bed most of the time because of my back.

Score: _____/24 = _____ **Improvement:** _____ **%**

Patient Signature: _____