# ACCIDENT/INJURY QUESTIONNAIRE

**Name:** (Last, First MI)_____ **Today's Date:** _____

## AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- **Was anyone else in the vehicle with you?** ☐ **No** ☐ **Yes** - *(Number of people)* _____
- **You were?** ☐ **Front seat** – *Driver / Passenger* ☐ **Rear Seat**– Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- **Name of Driver**, *if not self*: _____ **Name of Driver of other vehicle:** _____
- **Did airbags deploy?** ☐ **No** ☐ **Yes** **Did Police arrive?** ☐ **No** ☐ **Yes** **Using Seatbelt?** ☐ **No** ☐ **Yes**
- **Did you strike the windshield or object in car?** ☐ **No** ☐ **Yes** - *(Describe)* _____
- **Were you knocked unconscious?** ☐ **No** ☐ **Yes** *(How long?)* _____
- **Where was your vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Where was the other vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Your Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:**_____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____
- **Other's Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:**_____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

## WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

**Employer:** _____ **Occupation:** _____ **Claim #:** _____
**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____
**Contact Person:** _____ **Phone:** _____ **Email:** _____

## GENERAL ACCIDENT/INJURY INFORMATION – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

**Date of Accident:** ____/____/_____ **Time**: ___:_____ AM / PM

**Please describe the accident in as much detail as possible?** _____

_____

_____

_____

**Before the accident/injury:**

- **Have you ever had any complaints in the involved area before?** ☐ **No** ☐ **Yes**
  - *If yes* - **Were they present at the time of the accident/injury?** ☐ **No** ☐ **Yes**
    - *If yes* - **Summarize these complaints prior to the accident:** _____
- **Were you capable of performing all of your work activities without restriction?** ☐ **No** ☐ **Yes**

**At the time of the accident/injury:**

- **Did you feel pain immediately after the accident?** ☐ **No** ☐ **Yes** ☐ **Later that day** ☐ **Next day** ☐ **When?** _____
- **Were you taken anywhere after the accident?** ☐ **No** ☐ **Yes** ☐ **Later that day** ☐ **Next day** ☐ **When?** _____
  - *If yes,* **How?**_____ **Where?**_____
  - *If yes,* **Did you receive treatment?** ☐ **No** ☐ **Yes** - *(Describe)* _____

**Since the accident/injury:**

- **Are your symptoms:** ☐ **Improving?** ☐ **Getting Worse?** ☐ **The Same?**
- **Are your work activities restricted as a result of this accident/injury?** ☐ **No** ☐ **Yes** - *( How?)* _____
- **Have you missed any work since this accident?** ☐ **No** ☐ **Yes** - *(Dates?)* _____
- **Have you retained an Attorney?** ☐ **No** ☐ **Yes - Name:**_____ **Phone:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Patient No:** _____

# INTRODUCTION PATIENT CASE HISTORY

**Today's Date:** _____

## PATIENT INFORMATION

**Name:** (Last, First MI)_____ **Preferred Name**: _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Home:** _____ **Mobile:** _____ **Mobile Carrier:** _____ **Work:** _____

**Email:** _____ **Gender:** M / F **Marital Status:** Married / Other / Single

**Social Security #**:_____ **Date of Birth:** _____

**Student Status:** Full Student / Part Student / Non-Student ☐ **Employed** **Employer:** _____

***Referred By:** _____

**Ethnicity**: Hispanic or Latino / Other **Preferred Language:** _____

**Race:** Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White **Smoking Status**: Every Day / Some Days / Former / Never

## EMERGENCY CONTACT INFORMATION

**Full Name:** _____ **Primary Care Physician:** _____

**Home:** _____ **Mobile:** _____ **Doctor's Phone:** _____

**Relationship**: Child / Parent / Spouse / Other: _____

## FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury/Auto ☐ Other (please explain):_____

**PRIMARY INSURANCE**

**Name:** _____

**Relation to Insured:** Self / Spouse / Parent / Child / Other

*Other than Self:*
**Insured's Name**: _____ **Gender:** M / F

**Address**: _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____ **Date of Birth:** _____

**SECONDARY INSURANCE**

**Name:** _____

**Relation to Insured:** Self / Spouse / Parent / Child / Other

*Other than Self:*
**Insured's Name**: _____ **Gender:** M / F

**Address**: _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____ **Date of Birth:** _____

**Who is responsible for payment?** Self / Other - *(Relationship)* _____

*Other than Self:*
**Full Name**: _____ **Phone:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

***It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged***

**Patient No:** _____

# PATIENT CASE HISTORY

## HISTORY OF CURRENT CONDITION

**Describe Major Complaint:** _____

**Began When?** ____/_____/_____ **Describe how this began:**_____

_____

_____

**Grade Intensity/Severity of Complaint:** None / Mild / Moderate / Severe / Very Severe

**Quality of the complaint/pain**: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

**How frequent is the complaint present?** Off & On / Constant

**Does this complaint radiate/shoot to any areas of your body? No / Yes** *(Describe)*_____

*Head* - Base of Skull / Forehead / Sides-Temple R / L / Both

*Leg* - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

*Arm* – Across Shoulder / Elbow / Hand-Fingers R / L / Both

*Other Area:* _____

**Does anything make the complaint better?** Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

**Does anything make the complaint worse?** Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

**Which daily activities are being affected by this condition?** *(Describe)* _____

**For this CURRENT condition, have you:**

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: _____ **Where?** _____
- **Had any previous Surgery or Interventions in this area?** *(Describe)*_____
- **Taken any Medications?** OTC / Prescriptions _____
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: _____ **When and Where?** _____

**Describe any Secondary Complaints:** _____

## HEALTH HISTORY – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

### *Medications:*

**Allergies to Medications:** ***NONE*** *(List)* _____

_____

**Current Medications:** ***NONE***

*(Already have a list? We can make a copy.)*_____

_____

_____

_____

_____

### *Past Health History:* *(Please list any past…)*

**Surgeries – Date, Type, and Reason:** ***NONE***

_____

_____

_____

_____

**Major Injuries/Traumas:** ***NONE*** _____

_____

_____

_____

**Major Hospitalizations:** ***NONE*** _____

_____

_____

**Patient No:** _____

### *Family Health History:* *(Please mark N/A if not relevant.)*

**List *relevant* major health problems of immediate relatives:**

_____

_____

_____

**Deaths in immediate family:** *(Cause and at what Age?)*

_____

_____

_____

### *Social and Occupational History:*

**Level of Education Completed:** _____

High School / Some College / College Grad. / Post Grad. / Other

**Lifestyle:** *(Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)*

_____

_____

_____

_____

**Habits:**

Cigarettes – *(#/day)* _____

Alcohol – *(amount/day)*_____

Coffee/Tea – *(cups/day)*_____

Rec. Drugs *(List)*_____

**Are you *currently* experiencing any of these symptoms? *(Check all the apply)***
**Many of the following conditions respond to Chiropractic and Acupuncture treatment.**

**General:** *(constitutional)*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this Category*

**Musculoskeletal:**
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems _____
- ☐ Leg Problems _____
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ *None in this Category*

**Neurological:**
- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Have you ever had a head injury?
- ☐ Ever been in an auto accident?
- ☐ Other: _____
- ☐ *None in this Category*

**Mind/Stress:**
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *None in this Category*

**Genitourinary:**
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: _____
- ☐ *None in this Category*

**Gastrointestinal:**
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ *None in this Category*

**Cardiovascular & Heart:**
- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: _____
- ☐ *None in this Category*

**Respiratory:**
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: _____
- ☐ *None in this Category*

**Eyes and Vision:**
- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: _____
- ☐ *None in this Category*

**Ears, Nose and Throat:**
- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Sinus / Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: _____
- ☐ *None in this Category*

**Endocrine, Hematologic, and Lymphatic:**
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: _____
- ☐ *None in this Category*

**Skin and Breasts:**
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: _____
- ☐ *None in this Category*

**Women Only:**

**Are you pregnant?**
- ☐ **Yes -** ***Due Date*** ___/___/____
- ☐ **No -** ***Last Menstrual Period*** ___/___/____
- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other: _____
- ☐ *None in this Category*

***Pregnancies with Outcome & Date:***
_____
_____
_____

**Comments:** _____

_____

*I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.*

Patient or Guardian Signature _____ Date_____

Treating Doctor Signature DR. Adam Meylor DC Adam Meylor Date_____

**Patient No:** _____

# Functional Rating Index

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

### 1. Pain Intensity

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |

### 2. Sleeping

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Perfect sleep | Mildly disturbed sleep | Moderately disturbed sleep | Greatly disturbed sleep | Totally disturbed sleep |

### 3. Personal Care (washing, dressing, etc.)

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain; no restrictions | Mild pain; no restrictions | Moderate pain; need to go slowly | Moderate pain; need some assistance | Severe pain; need 100% assistance |

### 4. Travel (driving, etc.)

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain on long trips | Mild pain on long trips | Moderate pain on long trips | Moderate pain on short trips | Severe pain on short trips |

### 5. Work

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can do usual work plus unlimited extra work | Can do usual work; no extra work | Can do 50% of usual work | Can do 25% of usual work | Cannot work |

**Work**_____

**PRINTED**

_____

**Signature**

### 6. Recreation

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can do all activities | Can do most activities | Can do some activities | Can do a few activities | Cannot do any acitivies |

### 7. Frequency of pain

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain | Occasional pain; 25% of the day | Intermittent pain; 50% of the day | Frequent pain; 75% of the day | Constant pain; 100% of the day |

### 8. Lifting

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain with heavy weight | Increased pain with heavy weight | Increased pain with heavy weight | Increased pain with light weight | Increased pain with any weight |

### 9. Walking

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain with any distance | Increased pain with after 1 mile | Increased pain with after 1/2 mile | Increased pain with after 1/4 mile | Increased pain with all walking |

### 10. Standing

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain after several hours | Increased pain after several hours | Increased pain after 1 hour | Increased pain after 1/2 hour | Increased pain with any standing |

**Total Score** _____

_____

**Date**