Accident History Questionnaire

PERSONAL INJURY PATIENT HISTORY

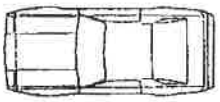
Name _____ Date _____

Address _____ Phone Number _____

Cell Phone _____ Email _____

1. Date of Accident: _____ 2. Time: _____ AM/PM
3. Driver of Car: _____ 4. Where were you seated? _____
5. Who owns the car? _____
6. Year & Model of your car. _____

   Year & Model of other car. _____
7. What was the approximate damage done to your car? $ _____
8. Visibility at time of accident: ☐ poor ☐ fair ☐ good ☐ other: _____
9. Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dark ☐ other (describe): _____
10. Where was your car struck?

    FRONT  REAR

    In your own words, please describe accident: _____
11. Type of Collision: ☐ Head-on ☐ Broad-side ☐ Front Impact ☐ Rear-end car in front ☐ Rear impact ☐ Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: _____
13. Did you see the accident coming? ☐ yes ☐ no → 14. Did you brace for impact? ☐ yes ☐ no
15. Were seatbelts worn? ☐ yes ☐ no → 16. Were shoulder harnesses worn? ☐ yes ☐ no
17. Does you car have headrests? ☐ yes ☐ no
18. If yes, what was the position of those headrests compared to your head before the accident?
    ☐ Top of headrest even with **bottom** of head ☐ Top of headrest even with **top** of head
    ☐ Top of headrest even with **middle** of neck
19. Was your car braking? ☐ yes ☐ no → 20. Was your car moving at the time of the accident? ☐ yes ☐ no
21. If yes, how fast would you estimate you were going? _____ mph → 22. the other car? _____ mph
23. Head/Body position at the time of impact:
    ☐ Head turned left/right ☐ Head looking back ☐ Head straight forward
    ☐ Body straight in sitting position ☐ Body rotated right/left ☐ Other:
24. As a result of the accident you were:
    ☐ Rendered unconscious ☐ In shock ☐ Dazed, circumstances vague ☐ Other:
25. How was the shoulder harness adjusted? ☐ Loose ☐ Snug
26. Were you wearing a hat or glasses? ☐ yes ☐ no
27. Could you move all parts of your body? ☐ yes ☐ no
28. If no, what parts couldn't you move and why? _____
29. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No
30. If no, why not? _____
31. Did you get any bleeding cuts? ☐ yes ☐ no If yes, where? _____
32. Did you get any bruises? ☐ yes ☐ no If yes, where? _____
33. Describe how you felt immediately after the accident: _____

    Later that day: _____

    The next day: _____

34. Check symptoms apparent since the accident:

☐ Headache	☐ Chest pain	☐ Neck pain/Stiffness	☐ Mid back pain	☐ Light sensitivity
☐ Anxious/Nervousness	☐ Pain behind eyes	☐ Dizziness	☐ Low back pain	☐ Sleeping problems
☐ Numbness in fingers	☐ Loss of smell	☐ Numbness in toes	☐ Fainting	☐ Cold feet
☐ Facial Pain	☐ Loss of memory	☐ Fatigue	☐ Breath shortness	☐ Loss of taste
☐ Irritability	☐ Depression	☐ Ringing/Buzzing	☐ Cold Sweats	☐ Loss of balance
☐ Tension	☐ Constipation	☐ Cold hands	☐ Clicking / Popping Jaw	
☐ Diarrhea	☐ Other_____			

35. Occupation:_____ 36. Employer:_____

37. Have you missed time from work: ☐ yes ☐ no

38. If yes, full time off work: _____to_____

39. If yes, part time off work: _____to_____

40. Did you seek medical help immediately after the accident? ☐ yes ☐ no

41. If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone drove me ☐ Drove myself ☐ Other:_____

42. Doctor #1: Name: _____ 43. First Visit Date: _____

44. Were you examined? ☐ yes ☐ no → 45. Were X-rays taken? ☐ yes ☐ no

46. Did you receive treatment? ☐ yes ☐ no ☐ Medications ☐ Braces ☐ Collars

47. If yes, what kind of treatment did you receive?_____

48. What benefits did you receive from the treatment?_____

49. Date of last treatment? _____

50. Doctor #2: Name: _____ 51. First Visit Date: _____

52. Were you examined? ☐ yes ☐ no → 53. Were X-rays taken? ☐ yes ☐ no

54. Did you receive treatment? ☐ yes ☐ no ☐ Medications ☐ Braces ☐ Collars

55. If yes, what kind of treatment did you receive?_____

56. What benefits did you receive from the treatment?_____

57. Date of last treatment: _____

58. Do you have an attorney on this claim? ☐ yes ☐ no

59. If yes, who? _____

Address _____

City _____ State _____ Zip _____ Phone _____

Illustrate how the accident happened.

PAST MEDICAL HISTORY: Place an (X) if it applies and describe.

☐ None related to current complaints ☐ Hospital or operation ☐ Auto Accident ☐ Work Accident ☐ Illness ☐ Other

Describe _____

_____

FAMILY HISTORY: Place an (X) if any family member has suffered from:

☐ Tuberculosis ☐ Kidney Disease ☐ Spinal Disorder ☐ Mental Illness ☐ Epilepsy
☐ Diabetes ☐ Gout ☐ Allergy ☐ Arthritis ☐ Hypertension
☐ Cancer ☐ Migraines ☐ Heart Attack ☐ Other, list:_____

PERSONAL HISTORY: Place an (X) if it applies, describe.

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower Employed Spouse? ☐ yes ☐ no

Number of Children _____ Number of Children at home _____ Are you pregnant? ☐ yes ☐ no ☐ not sure

Medications, describe _____

_____

Disease, describe _____

_____

Other, describe _____

SYSTEM REVIEW Place an (X) next to the symptoms you know you have

GENITO-URINARY SYSTEM

☐ Bladder trouble ☐ Excessive urination ☐ Scanty urination ☐ Painful urination ☐ Disclosed urine

GASTRO-INTESTINAL SYSTEM

☐ Poor appetite ☐ Excessive hunger ☐ Difficult chewing ☐ Difficult swallowing ☐ Excessive thirst ☐ Nausea
☐ Vomiting food ☐ Abdominal pain ☐ Diarrhea ☐ Constipation ☐ Black stool ☐ Bloody stool
☐ Hemorrhoids ☐ Liver trouble ☐ Weight trouble ☐ Gall bladder trouble

NERVOUS SYSTEM

☐ Numbness ☐ Loss of feeling ☐ Paralysis ☐ Dizziness ☐ Fainting ☐ Headaches
☐ Muscle jerking ☐ Convulsions ☐ Forgetfulness ☐ Confusion ☐ Depression

CARDIO-VASCULAR SYSTEM

☐ Chest pain ☐ Pain over heart ☐ Difficult breathing ☐ Persistent cough ☐ Coughing blood ☐ Coughing phlegm
☐ Rapid heartbeat ☐ High blood pressure ☐ Heart problems ☐ Lung problems ☐ Varicose veins ☐ Other

EYES, EARS, NOSE AND THROAT SYSTEM

☐ Eye strain ☐ Eye inflammation ☐ Vision problems ☐ Ear pain ☐ Ear noises ☐ Ear discharge
☐ Hearing loss ☐ Breathing Difficulty ☐ Nose bleeding ☐ Nose discharge ☐ Sore gums ☐ Nose Pain
☐ Sore mouth ☐ Sore throat ☐ Hoarseness ☐ Speech difficulty ☐ Dental problems

ACTIVITIES OF DAILY LIVING ASSESSMENT

Directions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section which most closely applies to you.

SECTION 1: PAIN INTENSITY

☐ I can tolerate the pain I have without using pain killers.
☐ The pain is bad but I manage without taking pain killers.
☐ Pain killers give complete relief from pain.
☐ Pain killers give moderate relief from pain.
☐ Pain killers give very little relief from pain.
☐ Pain killers give no relief from pain. I do not use them.

SECTION 2 : PERSONAL CARE

☐ 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 the most aspects of self care.
☐ I do not get dressed, 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 causes extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on a table).
☐ Pain prevents me from lifting heavy weights. I can manage light to medium weights if they are conveniently positioned.
☐ I can lift only very light weights.
☐ I cannot lift or carry anything at all.

SECTION 4: WALKING

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk using a cane or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

SECTION 5: SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than one hour.
- ☐ Pain prevents me from sitting for more than 30 minutes.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

SECTION 6: STANDING

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it causes extra pain.
- ☐ Pain prevents me from standing for more than one hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7: SLEEPING

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

SECTION 8: SEX LIFE

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

SECTION 9: SOCIAL LIFE

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc.).
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 10: TRAVELING

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain restricts me to the journeys of less than one hour.
- ☐ Pain restricts me to short necessary trips under a 1/2 hour.
- ☐ Pain restricts me from traveling except to the doctor or hospital.

CURRENT CHIEF COMPLAINTS:

Place an (X) in the appropriate complaint areas.

SPINE

☐ Low back ☐ Mid back ☐ Neck ☐ Pelvis

UPPER EXTREMITY

☐ Shoulder R/L ☐ Arm R/L ☐ Elbow R/L
☐ Wrist R/L ☐ Forearm R/L ☐ Hand R/L

LOWER EXTREMITY

☐ Hip R/L ☐ Thigh R/L ☐ Knee R/L
☐ Leg R/L ☐ Ankle R/L ☐ Foot R/L

OTHER (describe): _____

_____

SUBJECTIVE PAIN LEVEL:

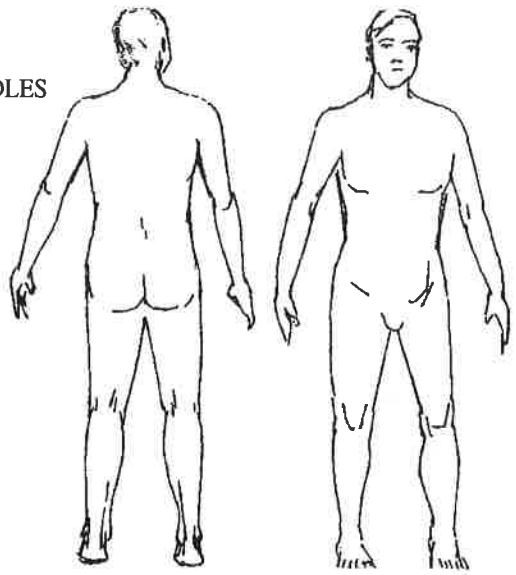
On a scale of 1 - 10, place an (X) in your current pain level

NORMAL ——— **EMERGENCY**

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

Mark the areas of your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.

× NUMBNESS
\+ BURNING
○ PIN & NEEDLES
= STABBING



Patient's Signature

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

MONSON CHIROPRACTIC CLINIC, P.C.

3779 North Alpine Road
Rockford, Illinois 61114
Telephone: (815) 633-9115
(815) 633-9152
Fax: (815) 633-8745

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS AND/OR INFORMATION- (To Monson Chiropractic Clinic)

PATIENT'S NAME: _____ **PATIENT'S NUMBER:** _____

DATE OF BIRTH: _____ **TELEPHONE:** _____

ADDRESS: _____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

I HEAREBY AUTHORIZE AND REQUEST:

INSTITUTION OR INDIVIDUAL:_____

STREET ADDRESS:_____

CITY, STATE AND ZIP:_____

_____**COMPLETE RECORDS**

_____ **X-RAYS AND/OR X-RAYS REPORTS** **PURPOSE: FOR DIAGNOSTIC**

I fully understand that my medical records may contain psychiatric, mental heath, developmental disabilities, alcohol and/or drug abuse information, and/or Acquired Immune Deficiency Syndrome (AIDS)/HIV test results and/or information. Only records and/or information believed necessary for the purpose expressed above shall be released and disclosed. I may inspect and arrange for photocopies of the records/information that are to be disclosed. This release may NOT include hospital records or records from another physician that were sent to us, however, for insurance purposes, hospital records could be included.

I understand that my refusal to consent to the release of the above-mentioned information will prevent the disclosure of this information. I understand that if this authorization is for the purpose of third party payment, that medical information as may be necessary to process benefits will be disclosed to my insurance company and/or insurance company's review aversely affects my entitlement to insurance benefits.

I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance thereon. This authorization for release of information expires 90 days or _____, unless I revoke it.

_____ _____

Signature of patient or guardian **Date**

MONSON CHIROPRACTIC CLINIC, P.C.

3779 North Alpine Road
Rockford, Illinois 61114
Telephone: (815) 633-9115
(815) 633-9152
Fax: (815) 633-8745

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent For Use of Health Information

Name_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

The following individuals have my permission to access my Patient Health Information.

Name	Relationship	Expiration Date

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures. I also give permission for the above-mentioned person(s) to access my Patient Health Information Records.

Dated this _____ day of _____, 20___.

_____
Patient Signature

_____
Witness

If patient is a minor or under a guardianship order as defined by State Law:

_____
Parent/Guardian Signature (circle one)