

# NEW PATIENT QUESTIONNAIRE – AUTOMOBILE ACCIDENT

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Occupation (includes homemaking) \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Email \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex M F Marriage Status: M S W D # Children \_\_\_\_\_

Referred by \_\_\_\_\_ Condition due to accident or injury? Y  N

Accident Occurred at Work? Y  N  When? \_\_\_\_\_

Auto Accident Related? Y  N  When? \_\_\_\_\_

## SYMPTOM/PAIN INFORMATION

### HEAD:

- Headache
  - entire head
  - back of head
  - forehead
  - temples
  - migraine
- Head feels heavy
- Loss of memory
- Light-headedness
- Fainting
- Lights bother eyes
- Loss of smell
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Buzzing in ears

### NECK:

- Pain in neck
- Neck pain on movement
- Pinched nerve in neck
- Neck feels out of place
- Stiff neck
- Muscles spasms in neck
- Grinding sounds in neck
- Grating sounds in neck
- Popping sounds in neck
- Arthritis in neck

### LOW BACK:

- Low back pain
- Low back pain is worse when:
  - working
  - lifting
  - stooping
  - standing
  - sitting
  - bending
  - coughing
- Pinched nerve in low back
- Slipped disc
- Low back feels out of place
- Muscle spasms
- Arthritis

### MID BACK:

- Midback pain
- Pain between shoulder blades
- Sharp stabbing pain in mid-back
- Muscle spasms
- Hurts to take deep breath

### ABDOMEN:

- Nervous stomach
- Nausea
- Gas
- Constipation
- Diarrhea
- Stomach pain after meal
- Difficult reclining after meal

### SHOULDERS:

- Pain in shoulder R L
- Pain across shoulders
- Bursitis R L
- Arthritis R L
- Can't raise arm
  - Above shoulder level
  - over head
- Tension in shoulder R L
- Muscle spasms shoulder
- Frozen shoulder

### ARM & HANDS:

- Pain in upper arm
- Pain in forearm
- Pain in hands
- Pain in fingers
- Pinched nerve arm
- Pinched nerve fingers
- Feeling of pins & needles in arms
- Feeling of pins & needles in fingers
- Fingers go to sleep
- Hands feel cold
- Swollen finger joints
- Sore finger joints
- Arthritis in fingers
- Loss of grip strength
- Tennis elbow
- Carpal Tunnel

### HIPS, LEGS & FEET:

- Pain in buttocks R L
- Pain in hip joint R L
- Pain down leg R L
- Pain down both legs
- Leg cramps
- Pins & needles in legs R L
- Numbness of leg R L
- Numbness of feet R L
- Numbness of toes R L
- Feet feel cold
- Cramps in feet R L
- Sprained ankle R L
- Swollen feet R L
- Painful joints in toes
- Pain in foot R L
- Pain in knee R L

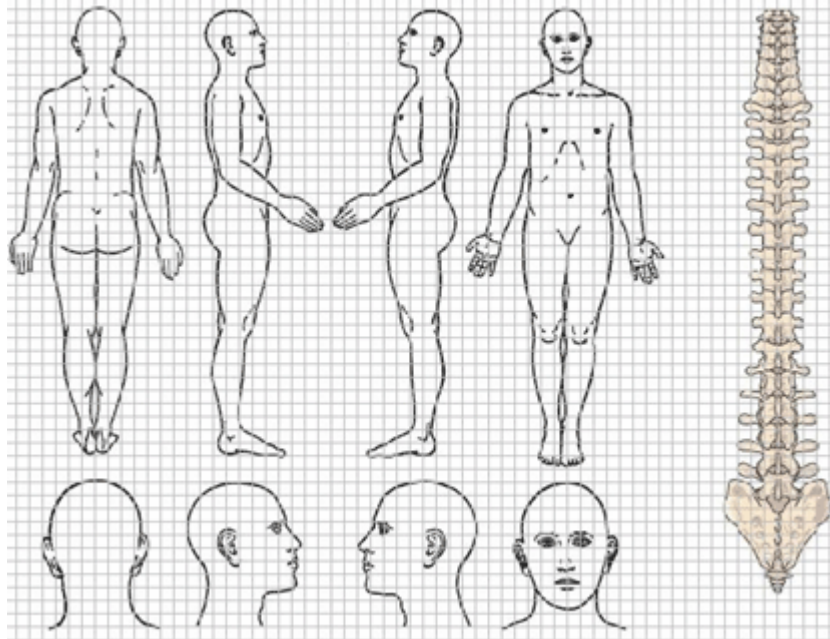
### CHEST:

- Chest pain
- Pain around ribs
- Shortness of breath

### GENERAL:

- Nervousness
- Irritable
- Depressed
- Fatigue
- Generally feel run-down
- Loss of sleep
- Loss of weight
- Migratory pains

- Please describe the health problem for which you came to our office. \_\_\_\_\_  
\_\_\_\_\_
- Describe the character of your symptom(s). Some words often used might include burning, tingling, aching, tired, numb, sharp, dull, stabbing, shooting, radiating, etc. \_\_\_\_\_  
\_\_\_\_\_
- Shade in the areas on the diagram where you feel discomfort or symptoms.



- Please put a mark on the scale to show how bad your usual discomfort has been recently. If you are describing more than one symptom indicate the level of pain for each symptom.  
Symptom(s)

	No	0	1	2	3	4	5	6	7	8	9	10	Worse Possible Discomfort
	Discomfort	0	1	2	3	4	5	6	7	8	9	10	

- How long have you had this episode of symptoms? \_\_\_\_\_
- How many times have you had a problem similar to or the same as this in the past?
  - None previously
  - 1-5 episodes
  - 6-10 episodes
  - More than 10 episodes
  - Single episode of continuous pain
- When was the very first time you ever felt something similar to or the same as your current problem?
  - Less than 6 months ago
  - 6 months – 1 year ago
  - 1 - 5 years ago
  - 5 - 10 years ago
  - 10 - 20 years ago
  - More than 20 years ago
- Did symptoms begin gradually over time or suddenly? \_\_\_\_\_
- Since your symptoms began, have they  improved  worsened  stayed the same?
- Are your symptoms constant?  Yes  No What caused your symptoms to occur (physical overuse, mental stress, accident, etc)? PLEASE BE SPECIFIC \_\_\_\_\_  
\_\_\_\_\_

11. What posture, movement, or behavior makes your condition worse? \_\_\_\_\_  
\_\_\_\_\_
12. Is there any posture, exercise, movement or behavior that makes your condition better? \_\_\_\_\_  
\_\_\_\_\_
13. Is your sleep disturbed by your condition?  Yes  No  
Do you sleep on a:  mattress and box springs  waterbed  futon  other \_\_\_\_\_  
What is your normal sleeping position?  back  side  stomach  other \_\_\_\_\_
14. Are your symptoms better in the morning?  Yes  No Worse in the morning?  Yes  No  
Better in the evening?  Yes  No Worse in the evening?  Yes  No
15. Have you done anything to try to help or relieve your complaint other than medication such as  rest,  heat,  cold,  
 sitting,  lying down or  other? \_\_\_\_\_  
Describe \_\_\_\_\_
16. Please list whatever medications you are presently taking: \_\_\_\_\_  
\_\_\_\_\_
17. Do you exercise regularly?  Yes  No Please describe:  walking  running  swimming  weights  
 yoga  Pilates  bicycle  elliptical  other \_\_\_\_\_  
How many times per week or month? \_\_\_\_\_
18. Have you seen a chiropractor for this problem?  Yes  No If yes when? \_\_\_\_\_  
If applicable, the doctor's name and address: \_\_\_\_\_  
How much did it help? 

No Improvement	1	2	3	4	5	6	7	8	9	10	Full Improvement
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19. Have you seen a physical therapist for this problem?  Yes  No If yes when? \_\_\_\_\_  
How much did it help? 

No Improvement	1	2	3	4	5	6	7	8	9	10	Full Improvement
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20. Have you seen a medical doctor related to this problem?  Yes  No If yes when? \_\_\_\_\_  
Doctor's name and address: \_\_\_\_\_  
How much did it help? 

No Improvement	1	2	3	4	5	6	7	8	9	10	Full Improvement
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21. Have you had x-rays, CAT Scans, or MRI's for your condition?  Yes  No If yes when? \_\_\_\_\_  
Name and address of facility \_\_\_\_\_
22. Does your family have a history of any health problems? \_\_\_\_\_  
\_\_\_\_\_
23. Do you have a history of any serious illnesses or disorders? \_\_\_\_\_  
\_\_\_\_\_

24. Have you ever had any surgeries?  Yes  No If yes what kind and when? \_\_\_\_\_
25. Have you ever had serious injuries or broken bones?  Yes  No If yes what kind and when? \_\_\_\_\_
26. Do you have a specific diet?  Yes  No If yes what kind? \_\_\_\_\_
27. Do you vitamins or herbs?  Yes  No If yes what kinds? \_\_\_\_\_
28. Do you smoke any tobacco products?  Yes  No If yes how much and how often? \_\_\_\_\_
29. Do you drink any alcohol?  Yes  No If yes how much and how often? \_\_\_\_\_
30. Do you drink any caffeinated beverages?  Yes  No What kind(s)? \_\_\_\_\_  
How much and how often? \_\_\_\_\_

31. Describe your physical activity during the day:  
 Seated at computer  Extensive telephone use

Very Physical 1 2 3 4 5 Very Sedentary

Please check the appropriate response.

If "yes", please explain in the comments section below. If you are not sure, check the "?" box.

Yes	No	?		Yes	No	?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a past history of cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of significant trauma?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any unexplained weight loss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppression medication &/or condition?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your pain improve with rest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Minor trauma in person >50 years old?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you over 50 years old?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you over 70 years old?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failure to respond to a course of conservative care (4-6 weeks)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have osteoporosis (weak bones)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had spinal pain greater than 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acute onset urinary retention or overflow incontinence (wet underwear)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged use of corticosteroids (such as organ transplant Rx)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of anal sphincter tone or fecal incontinence (bowel accidents)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intravenous drug use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Saddle anesthesia (numbness in the groin region)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current or recent urinary tract, respiratory tract or other infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Global or progressive muscle weakness in the legs (legs give out)

**Women Only:**

- a. Are you pregnant or think you may be pregnant?  Yes  No
- b. Date of last menstrual period? \_\_\_\_\_
- c. Do you or have you ever suffered from any menstrual disorders?  Yes  No  
If yes please describe:

I certify that I have read and understand these prior four pages of information. To the best of my knowledge the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Date \_\_\_\_\_

Patients Signature \_\_\_\_\_

## HISTORY OF AUTOMOBILE ACCIDENT

Name \_\_\_\_\_ Date of Accident \_\_\_\_\_

1. The patient's vehicle is a  car  station wagon  SUV  Van  Truck  Motorcycle  Bicycle
2. Were you the  driver  passenger
3. Were you in the  front  rear
4. Were you in the  right  left or  middle seat
5. Did the other vehicle strike your vehicle  yes  no
6. Did your vehicle strike the other vehicle  yes  no
7. My vehicle was  at a stop  at a stop with foot on brake  moving  slowing down
8. Were you struck on the  front  rear  right or  left  side of car  right or  left
9. Were you pushed into the other vehicle(s)  yes  no; Describe \_\_\_\_\_  
\_\_\_\_\_
10. How many impacts did you feel? \_\_\_\_\_
11. Was damage to your vehicle  slight  moderate  severe  total
12. At the time of the impact were you:
  - Prepared for the crash/braced for the impact  Leaning on the arm rest
  - Unprepared for the crash/not braced for the impact  Stepping hard on the brakes
  - Holding onto the steering wheel tightly
13. At the time of the impact did any of the following occur?
  - I felt a forceful jolt and/or jarring  My body was thrown sideways
  - My body was thrown forward and backward  My head and neck were thrown abruptly sideways
  - My head and neck were thrown abruptly forward and backward
14. Were you wearing a seatbelt at the time of the accident?  yes  no
15. Did you strike any part of your body on any part of the car? If so, check the box next to the body part listed below, then check the box in the part of the car you hit on the opposite list and draw a line connecting both sides.

INJURED AREAS			AUTOMOBILE
<b>Forehead</b> <input type="checkbox"/> Middle Part <input type="checkbox"/> Left Side <input type="checkbox"/> Right Side			<input type="checkbox"/> <b>Steering Wheel</b>
<b>Face</b> <input type="checkbox"/> Cheeks <input type="checkbox"/> Nose <input type="checkbox"/> Mouth <input type="checkbox"/> Lips <input type="checkbox"/> Jaw			<input type="checkbox"/> <b>Dashboard</b>
<b>Head</b> <input type="checkbox"/> Left Side <input type="checkbox"/> Right Side <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head			<input type="checkbox"/> <b>Door Glass/Window</b>
<b>Arm</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<b>Elbow</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<b>Forearm</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> <b>Door Arm Rest</b>
<b>Hand</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<b>Wrist</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<b>Shoulder</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> <b>Passenger-side Door</b>
<b>Thigh</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<b>Knee</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<b>Leg</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> <b>Driver-side Door</b>
<b>Foot</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<b>Ankle</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<b>Hip</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> <b>Gas, Clutch, Brake Pedal</b>
<b>Spine</b> <input type="checkbox"/> Upper <input type="checkbox"/> Middle <input type="checkbox"/> Lower			<input type="checkbox"/> <b>Gear Box</b>
<b>Pelvis</b> <input type="checkbox"/> Right <input type="checkbox"/> Left		Sacroiliac Joint <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> <b>Roof of Car</b>
<b>Ribs</b> <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Right Side <input type="checkbox"/> Left Side			<input type="checkbox"/> <b>Not Certain</b>

16. Any other injuries to your body not listed? \_\_\_\_\_

17. Was the windshield broken on impact?  yes  no

18. Following the impact did you?  Faint  Blackout  Partially lose consciousness momentarily

19. Do you have a clear memory of the accident?  yes  no

20. Please check the box(s) that best describes how you felt immediately after the accident:

- |                                   |                                      |                                     |
|-----------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Nervous  | <input type="checkbox"/> Nauseated   | <input type="checkbox"/> Jittery    |
| <input type="checkbox"/> Stunned  | <input type="checkbox"/> Vomiting    | <input type="checkbox"/> Panicky    |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Lightheaded | <input type="checkbox"/> Crying     |
| <input type="checkbox"/> Scared   | <input type="checkbox"/> Dizzy       | <input type="checkbox"/> Hysterical |
| <input type="checkbox"/> Shocked  | <input type="checkbox"/> Dazed       |                                     |

21. When did your pain, stiffness, or other symptoms appear?

- |   |  |
|---|--|
| <input type="checkbox"/> At the scene of the accident                         | <input type="checkbox"/> Immediately following the accident    |
| <input type="checkbox"/> During the next several hours following the accident | <input type="checkbox"/> The next morning                      |
| <input type="checkbox"/> The next few days                                    | <input type="checkbox"/> Gradually over the next several weeks |

22. What were your symptoms following the accident?

- |   |  |
|---|--|
| <input type="checkbox"/> Headache                         | <input type="checkbox"/> Neck pain and/or stiffness          |
| <input type="checkbox"/> Mid-back pain and/or stiffness   | <input type="checkbox"/> Low-back pain and/or stiffness      |
| <input type="checkbox"/> Upper back pain and/or stiffness |  |
| Shoulder pain and/or stiffness                            | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| Arm pain and/or stiffness                                 | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| Hip pain and/or stiffness                                 | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| Leg pain and/or stiffness                                 | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| Knee pain and/or stiffness                                | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| Ankle/foot pain and/or stiffness                          | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| Jaw/TMJ pain and/or stiffness                             | <input type="checkbox"/> Right <input type="checkbox"/> Left |

23. Were you able to get out of the vehicle yourself?  yes  no If not, were you assisted by:

- paramedics  police  fire department  bystander  other \_\_\_\_\_

24. Following the accident did you go:  home  work  emergency room  \_\_\_\_\_

25. If you went to an emergency room or received any medical care following the accident, please provide the name(s) and address(es) of the hospital(s) and/or doctor(s).

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26. What type of treatment did you receive at the emergency room, paramedics, or any physicians you had seen?

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27. Since the accident are you:  Improved  Unchanged  Getting worse  
 Improved however, some problems are not resolving

28. Prior to the accident, have you ever had previous accident(s) which required medical care?  yes  no

29. What type of accident(s)?  auto accident  work related accident  slip and fall injury

What year(s)? \_\_\_\_\_

30. What major area(s) of your body was injured in previous accident(s)?  Head  Neck  Upper back  
 Middle back  Lower back  Arms/hands  Legs/feet  Jaw/TMJ

31. Did you fully recover from the injuries sustained in the previous accident(s)?  yes  no

32. Have you ever had any serious illnesses that required hospitalization?  yes  no If yes, describe:

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33. Have you had any nervous or mental illnesses?  yes  no

34. Have you had psychiatric care?  yes  no

35. Have you received a medical discharge from the armed forces?  yes  no

36. Have you returned to work since this accident?  yes  no If yes, have returned to work since your accident, please indicate which of the following statements below best describes your situation.

Part time only due to injuries  Full time work is only type available  
 Light duty due to accident injuries  Regular duty is only type work available

Work increases severity of symptoms:  mildly  moderately  severely

### CURRENT MEDICAL COMPLAINTS

#### BACK PAIN

37. Currently, I have pain in my:  Low back  Mid back  Upper back

38. Currently, I have stiffness in my:  Low back  Mid back  Upper back

39. My pain began after the accident:  yes  no

40. I have pain:  Sometimes (25%)  Half the time (50%)  Most of the time (75%)  All of the time (100%)

41. I have tingling and/or numbness in my:  Right leg  Left leg  Both

42. My pain is worse when I:

Cough or Sneeze <input type="checkbox"/> yes <input type="checkbox"/> no	Sit <input type="checkbox"/> yes <input type="checkbox"/> no	Bend <input type="checkbox"/> yes <input type="checkbox"/> no
Walk <input type="checkbox"/> yes <input type="checkbox"/> no	Lift <input type="checkbox"/> yes <input type="checkbox"/> no	Push <input type="checkbox"/> yes <input type="checkbox"/> no
Pull <input type="checkbox"/> yes <input type="checkbox"/> no	Stand <input type="checkbox"/> yes <input type="checkbox"/> no	Lay down <input type="checkbox"/> yes <input type="checkbox"/> no

43. My back is worse with daily activity  yes  no

44. My pain wakes me up during the night  yes  no

45. Changes in the weather affect my pain  yes  no

**NECK PAIN**

46. My neck pain began after the accident?  yes  no
47. I have pain:  Sometimes (25%)  Half the time (50%)  Most of the time (75%)  All of the time (100%)
48. I have stiffness:  Sometimes (25%)  Half the time (50%)  Most of the time (75%)  All of the time (100%)
49. My pain goes into my:  Right arm  Left arm  Both
50. I have tingling and/or numbness in my:  Right arm  Left arm  Both
51. My pain is worse when I:
- |  |  |   |
|--|--|---|
| Cough or Sneeze <input type="checkbox"/> yes <input type="checkbox"/> no | Turn head <input type="checkbox"/> yes <input type="checkbox"/> no | Bend <input type="checkbox"/> yes <input type="checkbox"/> no |
| Lift <input type="checkbox"/> yes <input type="checkbox"/> no            | Pull <input type="checkbox"/> yes <input type="checkbox"/> no      | Push <input type="checkbox"/> yes <input type="checkbox"/> no |
52. My pain wakes me up during the night.  yes  no
53. Changes in the weather affect my pain.  yes  no
54. I have headaches.  yes  no If yes, I get headaches, they occur:  
 Sometimes (25%)  Half the time (50%)  Most of the time (75%)  All of the time (100%)

**OTHER PAIN**

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition.

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**JOB DESCRIPTION**

In terms of an 8-hour workday: occasionally mean up to 2 hours, intermittently means up to 4 hours, frequently means up to 6 hours, and continuously means 6-8 hours.

55. In a typical 8-hour work day, I:

Sit	1	2	3	4	5	6	7	8	hours
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Stand	1	2	3	4	5	6	7	8	hours
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Walk	1	2	3	4	5	6	7	8	hours
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56. On the job, I perform the following activities (put an "X" in the appropriate box):

	Not at all	Occasionally	Intermittently	Frequently	Continuously
Bend/Stoop					
Squat					
Crawl					
Climb					
Reach above shoulder level					
Crouch					
Kneel					
Balancing					
Pushing/pulling					
Driving					
Twisting					



57. How much time on the job per day is spent in one position activity (for example: sitting and computer work)  
 Sometimes (25%)  Half the time (50%)  Most of the time (75%)  All of the time (100%)

58. Do you perform daily job activities involving repetitive use of any part of your body?  
 Sometimes (25%)  Half the time (50%)  Most of the time (75%)  All of the time (100%)

Describe \_\_\_\_\_

59. On the job, I lift (put an "X" in the appropriate box):

	Not at all	Occasionally	Intermittently	Frequently	Continuously
Up to 10 pounds					
11 to 24 pounds					
25 to 34 pounds					
35 to 50 pounds					
51 to 74 pounds					
75 to 100 pounds					

60. Do you have to bend over while doing any lifting or other activity?  yes  no Describe \_\_\_\_\_

\_\_\_\_\_

60. Please list any additional comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that I have read and understand these nine pages of information. To the best of my knowledge the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Date \_\_\_\_\_

Patients Signature \_\_\_\_\_