PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____/_____/_____ Sex: ❑M ❑F S/S# _____--_____--_____

Type of work: ❑Office/clerical ❑Light labor ❑Moderate labor ❑Heavy labor

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Attorney:

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? Yes / No Name(s) _____

NATURE OF ACCIDENT:

Date of Accident ____/_____/_____ Time of Day _____

Was the crash on-the-job? ❑Yes ❑No You were: ❑Driver ❑Front passenger ❑Rear passenger

❑Motorcycle operator ❑Motorcycle passenger ❑Other _____

Vehicle driven by: _____ Your vehicle (year, make, model): _____

Your estimated speed at moment of crash: _____mph ❑Stopped ❑Slowing ❑Accelerating

Other vehicle (year, make, model): _____

Time of day: ❑Daylight ❑Dawn ❑Dusk ❑Dark

Road conditions: ❑Dry ❑Damp ❑Wet ❑Snow ❑Ice ❑Other _____

Head restraints: ❑None ❑Integral type Adjustable type: ❑Up ❑Down ❑Don't know

If adjustable, was the position altered by the crash? ❑Yes ❑No

Was the seat back adjustment altered by the crash? ❑Yes ❑No Was the seat broken? ❑Yes ❑No

Lap belt: ❑Wearing ❑Not wearing ❑Don't know

Shoulder belt: ❑None ❑Wearing ❑Not wearing ❑Don't know

Did air bag deploy? ❑Yes ❑No If yes, were you struck? ❑Yes ❑No

Body position: ❑Good ❑Forward lean ❑Other_____

Head position: ❑Forward ❑Left ❑Right ❑Up ❑Down

Hands: ❑One on wheel ❑Two on wheel

Brakes applied? ❑Yes ❑No

Aware of impending crash? ❑Yes ❑No

Crash description:_____

_____

_____

_____

_____

_____

_____

_____

Crash Diagram:

During the crash:

What direction were you headed? ❑North ❑South ❑East ❑West

on (name of street) _____

What direction was other vehicle headed? ❑North ❑South ❑East ❑West

on (name of street) _____

Were you struck from: ❑Behind ❑Front ❑Left side ❑Right side

Did you strike any parts of the vehicle? ❑Yes ❑No

If yes, describe _____

Did vehicle strike any objects after crash?

If yes, describe _____

Wearing hat or glasses? ❑Yes ❑No

If yes, still on after crash? ❑Yes ❑No

Did you lose consciousness? ❑Yes ❑No

If yes, for how long? _____

Estimated property damage to your vehicle: $_____

Estimated damage to other vehicle(s): ❑None ❑Minimal ❑Moderate ❑Major

Were the police on-scene? ❑Yes ❑No If yes, was a report made? ❑Yes ❑No

After the crash:

Symptoms: ❑Headache ❑Dizziness ❑Nausea ❑Confusion/disorientation ❑Neck pain

Paresthesia(s)

If yes, where?_____

Extremity pain. If yes, where?_____

❑Back pain When did SX first appear? ❑Immediately (describe which SX) ❑hr afterward

Where did you go after crash? ❑Home ❑Work ❑Hospital: _____

Mode of transportation _____ Pvt. doctor:_____

Emergency department:

Radiographs: ❑Yes ❑No Body parts imaged _____

Results_____

Lab work: ❑Yes ❑No ❑Cervical collar ❑Ice

Medications:_____

Other:_____

Follow-up instructions:_____ ❑None

Treatment History:

1. Dr.: _____ Specialty: _____

Date first seen:___/_____/_____ Referred by:_____ TX type:_____

TX frequency:_____ TX duration:_____ Currently treating? ❑Yes ❑No

Any disability? ❑Yes ❑No

If yes, describe:_____

Special tests:_____ Referred to:_____

Did TX help? ❑Yes ❑No

2. Dr.: _____ Specialty: _____

Date first seen:___/_____/_____ Referred by:_____ TX type:_____

TX frequency:_____ TX duration:_____ Currently treating? ❑Yes ❑No

Any disability? ❑Yes ❑No

If yes, describe:_____

Special tests:_____ Referred to:_____

Did TX help? ❑Yes ❑No

Past medical history:

Surgeries (dates and residuals):_____

_____

_____

Fractures (dates and residuals):_____

_____

Serious illness (dates and residuals):_____

_____

_____

Workers' comp. injuries (date, TX, awards, residuals):_____

_____

Personal Injuries (date, TX, awards, residuals):_____

_____

Sports or other injuries to head, neck, or back:_____

_____

Other:

Did you have any physical complaints BEFORE THE ACCIDENT? ❑Yes ❑No

If yes, please describe in detail: _____

_____

_____

Have you lost time from work as a result of this accident? ❑Yes ❑No

Last Day Worked: _____

Type of Employment: _____

Are you being compensated for the time lost from work? ❑Yes ❑No

Other pertinent information: _____

_____

_____

Responsibility for Payment

As a courtesy to you, we will gladly submit your charges to your insurance company and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive.

_____ _____

Patient's Signature Date

FINANCIAL AGREEMENT
PERSONAL INJURY

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

Party Responsibility
If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion or Personal Injury Protection portion of *your* automobile insurance policy to cover the treatment charges incurred in our office.

Med Pay: If you were a passenger in another vehicle, the insurance company that insures the automobile, may be billed for your medical services incurred.
3rd Party: If another vehicle has caused the accident, we will first bill *your* automobile Med Pay for coverage. If you do not have this type of coverage on your policy, you have three options.

1) You may hire an attorney (see below).
2) We will bill your private health insurance.
3) You may pay cash at the time of service.

Attorney Liens
If you hire an attorney to represent you, it is our policy to have your attorney sign a Doctor's Lien. *This lien must be signed and returned to our office before your second treatment.* This lien will guarantee direct payment to our office for any unpaid balance upon the settlement of your lawsuit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of our balance based upon the outcome of your settlement.

Responsibility for Payment
As a courtesy to you, we will gladly submit your charges to your insurance company and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive.
Release of Information
If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

We hope that this has answered any questions you might have regarding your financial arrangements. Once again, we'd like to welcome you to our office. If, at any time, you have any questions about your care, please don't hesitate to ask.

I have read and agree to the above.

_____ _____
Patient's Signature Date

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of 4 / 14 / 2003

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Greve Chiropractic with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

DIFFICULTY IN PERFORMING ACTIVITIES OF DALIY LIVING

PATIENT NAME: _____

Check each of the activities which you have difficulty performing and/or can perform only with pain. (There is no particular priority in the order presented.)

HOUSEWORK
___ Doing laundry
___ Making beds
___ Vacuuming
___ Washing dishes
___ Ironing
___ Carrying groceries
___ Caring for pets
___ Cooking
___ Other _____

YARDWORK
___ Mowing lawn
___ Raking leaves
___ Gardening

GENERAL
___ Walking
___ Standing
___ Running
___ Sitting
___ Lifting children
___ Bending
___ Climbing stairs
___ Chewing
___ Swimming
___ Sports:
List _____

PERSONAL GROOMING
___ Combing hair
___ Shaving
___ In/out bathtub
___ Brushing teeth
___ Other _____

TRAVEL
___ Driving
___ Riding (passenger)

MINUTES PER DAY
Type vehicle
Auto _____
Bus _____
Truck _____
Airplane _____

___ Getting in and out of auto
___ Playing piano
___ Using typewriter / computer
___ Kneeling
___ Sexual intercourse
___ Exercising
___ Using telephone
___ Sitting in recliner / couch
___ Reading
___ Lying in bed

OTHER: Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose:

_____
_____
_____
_____
_____

Signed: _____ **Date:** _____

Patient #:_____

NECK DISABILITY INDEX

NAME_____DATE:_____SCORE_____

Please read carefully: *This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the* ***ONE CHOICE*** *that most applies to you. We realize that you may feel that more than one statement may relate to you, but* ***PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.***

SECTION 1 - Pain Intensity

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
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.

SECTION 2 - 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 manage most of my personal care.
4. I need help every day in most aspects of self-care.
5. I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 - Lifting

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

SECTION 4 - Reading

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

SECTION 5 - 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.

SECTION 6 - Concentration

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

SECTION 7 - Work

0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can 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.

SECTION 8 - Driving

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

SECTION 9 - Sleeping

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

SECTION 10 - Recreation

0. I am able to engage in all my recreation activities with no neck pain at all.
1. I am able to engage in all my recreation activities with some pain in my neck.
2. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
3. I am able to engage in a few of my usual recreation activities because of pain in my neck.
4. I can hardly do any recreation activities because of pain in my neck.
5. I cannot do any recreation activities at all.

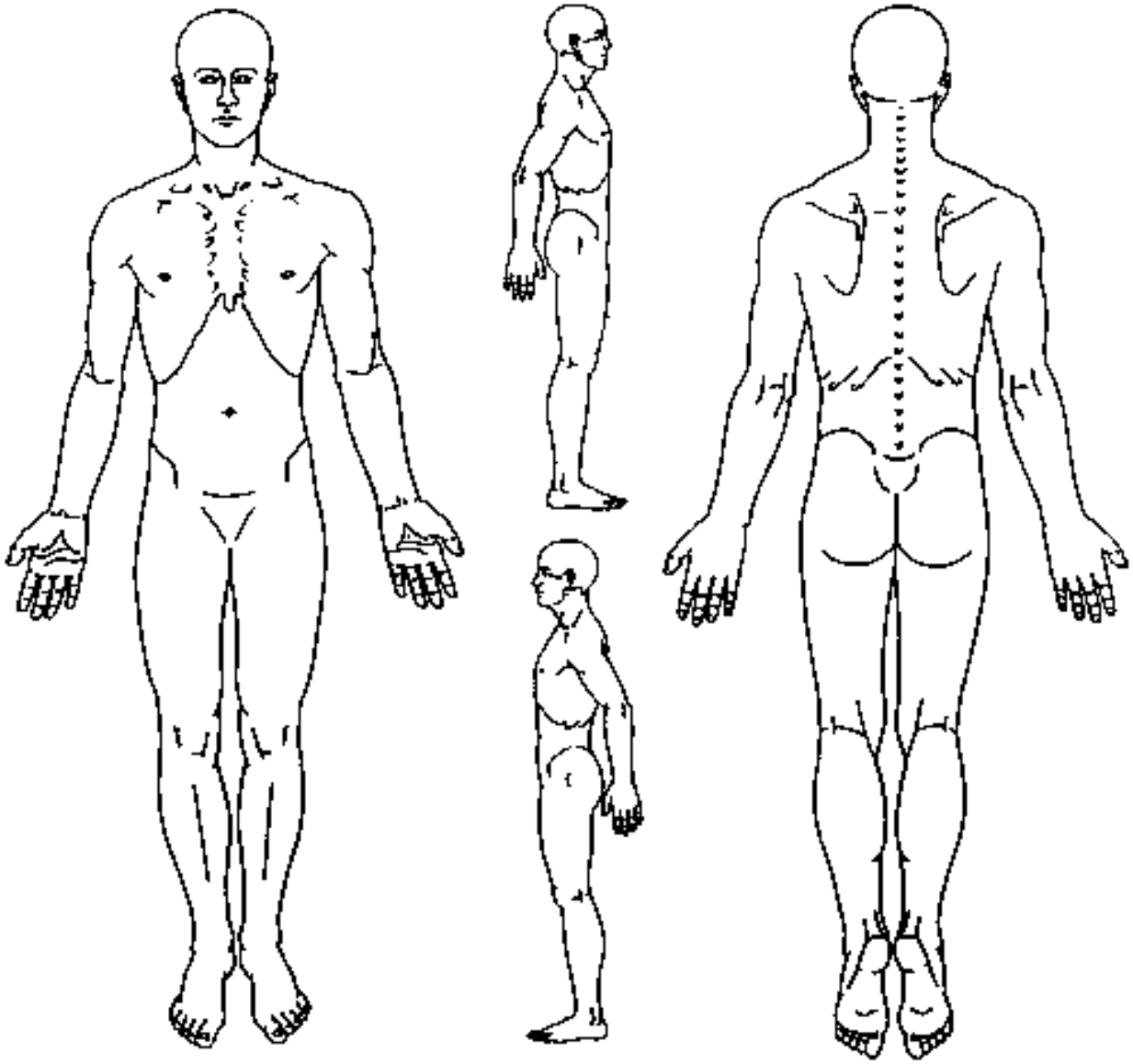
OTHER COMMENTS:_____

THE NECK DISABILITY INDEX QUESTIONNAIRE

NAME _____ DATE _____

How long have you had neck pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



A = ACHE **B** = BURNING **N** = NUMBNESS
P = PINS & NEEDLES **S** = STABBING **O** = OTHER

OVER PLEASE ⇒

Patient #:_____

THE OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME_____DATE:_____SCORE:_____

Please read carefully: *This questionnaire is designed to enable us to understand how much your low back pain has affected you ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 - 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 severe.
5. The pain is severe and does not vary much.

SECTION 2 - Personal Care

0. I would 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 or dressing without help.

SECTION 3 - Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives me 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, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights, at the most.

SECTION 4 - Walking

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

SECTION 5 - Sitting

0. I can sit, without pain, 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 sitting more than one hour.
3. Pain prevents me sitting more than 1/2 hour.
4. Pain prevents me sitting more than ten minutes.
5. Pain prevents me from sitting at all.

SECTION 6 - 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 one hour without increasing pain.
3. I cannot stand for longer than 1/2 hour without increasing pain.
4. I cannot stand for longer than ten minutes without increasing pain.
5. I avoid standing because it increases pain right away.

SECTION 7 - 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 night's sleep is reduced by less than one-quarter.
3. Because of pain, my normal night's sleep is reduced by less than one-half.
4. Because of pain, my normal night's sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

SECTION 8 - Social Life

0. My social life is normal and give me no pain.
1. My social life is normal, but increases the degree of my pain.
2. Pain has no significant effect 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.

SECTION 9- 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 any worse.
2. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
3. I get extra pain while traveling which compels, me to seek alternative forms of travel.
4. Pain restricts all forms of travel.
5. Pain prevents all forms of travel except that done lying down.

SECTION-10 - 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 at present.
3. My pain is neither getting better nor worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

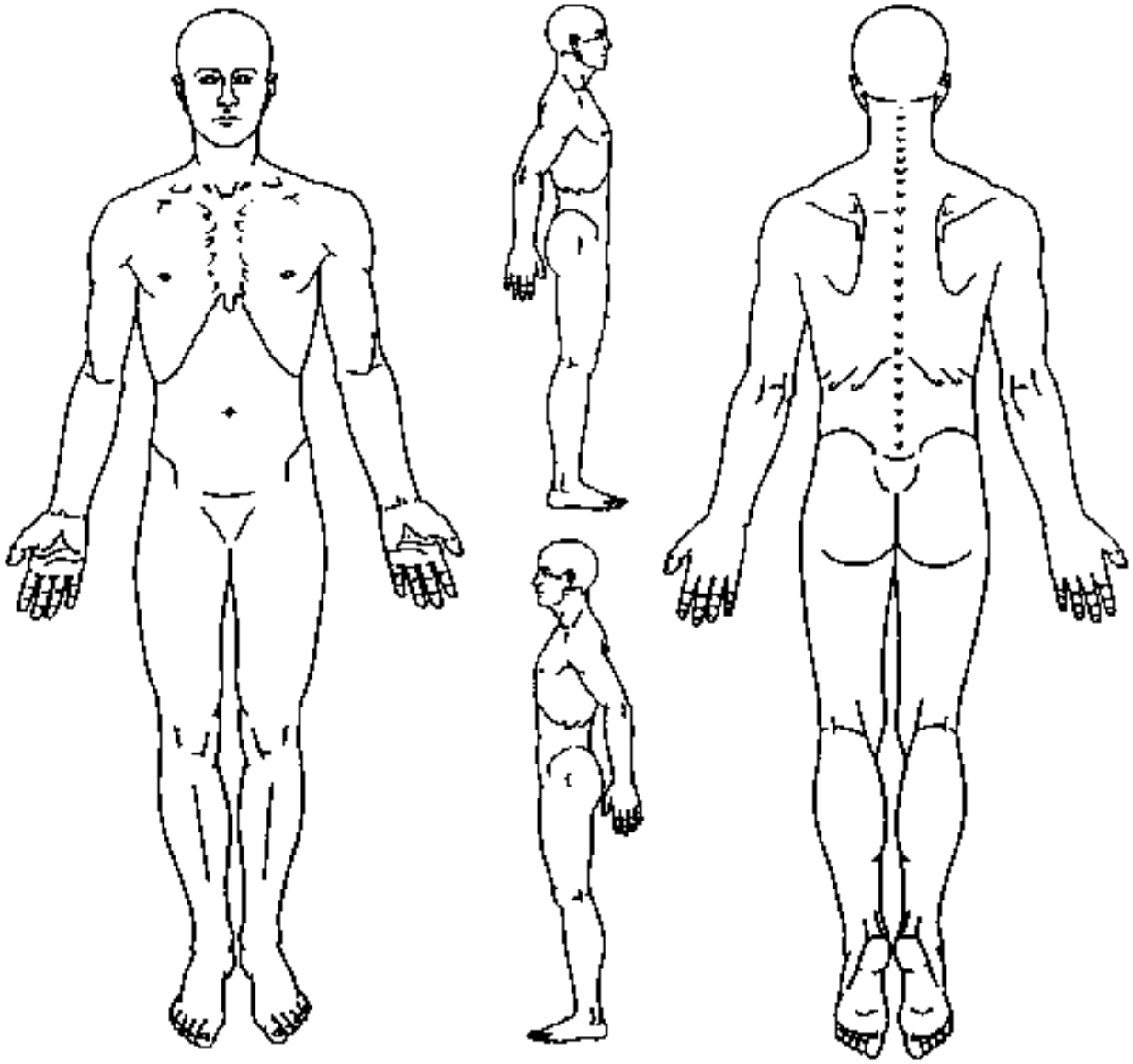
OTHER COMMENTS:_____

THE OSWESTRY LOW BACK INDEX QUESTIONNAIRE

NAME _____ DATE _____

How long have you had back pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



A = ACHE **B** = BURNING **N** = NUMBNESS
P = PINS & NEEDLES **S** = STABBING **O** = OTHER

OVER PLEASE ⇒