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 9 N 9

Accident Occurred at Work? Y 9 N 9 When? ___________________________________

Auto Accident Related? Y 9 N 9 When? ______________________________________

SYMPTOM/PAIN INFORMATION

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

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

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

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

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

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

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

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

CHEST:
- 9 Chest pain
- 9 Pain around ribs
- 9 Shortness of breath

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

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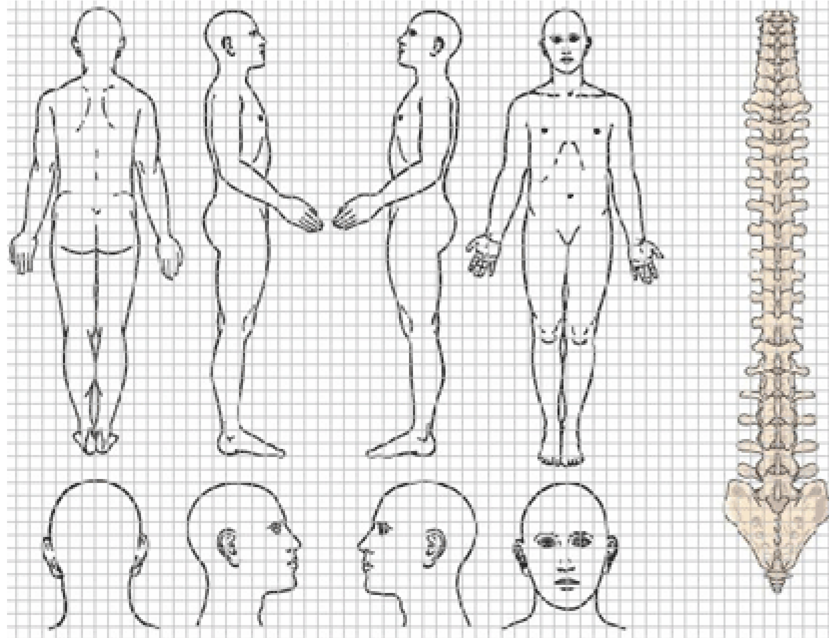
1. Please describe the health problem for which you came to our office. ______________________________

____

2. Describe the character of your symptom(s). Some words often used might include burning, tingling, aching, tired, numb, sharp, dull, stabbing, shooting, radiating, etc. ______________________________

____

3. Shade in the areas on the diagram where you feel discomfort or symptoms.



4. 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 Discomfort	0	1	2	3	4	5	6	7	8	9	10	Worse Possible Discomfort
		0	1	2	3	4	5	6	7	8	9	10	

5. How long have you had this episode of symptoms? ______________________________

6. How many times have you had a problem similar to or the same as this in the past?

   9 None previously
   9 1-5 episodes
   9 6-10 episodes
   9 More than 10 episodes
   9 Single episode of continuous pain

7. When was the very first time you ever felt something similar to or the same as your current problem?

   9 Less than 6 months ago
   9 6 months – 1 year ago
   9 1 - 5 years ago
   9 5 - 10 years ago
   9 10 - 20 years ago
   9 More than 20 years ago

8. Did symptoms begin gradually over time or suddenly? ______________________________

9. Since your symptoms began, have they 9 improved 9 worsened 9 stayed the same?

10. Are your symptoms constant? 9 Yes 9 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? 9 Yes 9 No

    Do you sleep on a: 9 mattress and box springs 9 waterbed 9 futon 9 other ___________________

    What is your normal sleeping position? 9 back 9 side 9 stomach 9 other ____________________

14. Are your symptoms better in the morning? 9 Yes 9 No Worse in the morning? 9 Yes 9 No

    Better in the evening? 9 Yes 9 No Worse in the evening? 9 Yes 9 No

15. Have you done anything to try to help or relieve your complaint other than medication such as 9 rest, 9 heat, 9 cold, 9 sitting, 9 lying down or 9 other? ____

    Describe ____

16. Please list whatever medications you are presently taking: ______________________________________

____

17. Do you exercise regularly? 9 Yes 9 No Please describe: 9 walking 9 running 9 swimming 9 weights

    9 yoga 9 Pilates 9 bicycle 9 elliptical 9 other ____

    How many times per week or month? ____

18. Have you seen a chiropractor for this problem? 9 Yes 9 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

19. Have you seen a physical therapist for this problem? 9 Yes 9 No If yes when?_____________________

    How much did it help? No Improvement 1 2 3 4 5 6 7 8 9 10 Full Improvement

20. Have you seen a medical doctor related to this problem? 9 Yes 9 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

21. Have you had x-rays, CAT Scans, or MRI's for your condition? 9 Yes 9 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? 9 Yes 9 No If yes what kind and when?____________________________

____

25. Have you ever had serious injuries or broken bones? 9 Yes 9 No If yes what kind and when?__________

____

26. Do you have a specific diet? 9 Yes 9 No If yes what kind?____

27. Do you vitamins or herbs? 9 Yes 9 No If yes what kinds?____

____

28. Do you smoke any tobacco products? 9 Yes 9 No If yes how much and how often?___________________

29. Do you drink any alcohol? 9 Yes 9 No If yes how much and how often?_____________________________

30. Do you drink any caffeinated beverages? 9 Yes 9 No What kind(s)? _________________________________

How much and how often?____

31. Describe your physical activity during the day:
9 Seated at computer 9 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	**?**	
9	9	9	Do you have a past history of cancer?
9	9	9	Have you had any unexplained weight loss?
9	9	9	Does your pain improve with rest?
9	9	9	Are you over 50 years old?
9	9	9	Failure to respond to a course of conservative care (4-6 weeks)?
9	9	9	Have you had spinal pain greater than 4 weeks?
9	9	9	Prolonged use of corticosteroids (such as organ transplant Rx)?
9	9	9	Intravenous drug use?
9	9	9	Current or recent urinary tract, respiratory tract or other infection?

Yes	No	**?**	
9	9	9	History of significant trauma?
9	9	9	Immunosuppression medication &/or condition?
9	9	9	Minor trauma in person >50 years old?
9	9	9	Are you over 70 years old?
9	9	9	Do you have osteoporosis (weak bones)?
9	9	9	Acute onset urinary retention or overflow incontinence (wet underwear)
9	9	9	Loss of anal sphincter tone or fecal incontinence (bowel accidents)
9	9	9	Saddle anesthesia (numbness in the groin region)
9	9	9	Global or progressive muscle weakness in the legs (legs give out)

____

____

Women Only:

a. Are you pregnant or think you may be pregnant? 9 Yes 9 No
b. Date of last menstrual period? ___________________________
c. Do you or have you ever suffered from any menstrual disorders? 9 Yes 9 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 9 car 9 station wagon 9 SUV 9 Van 9 Truck 9 Motorcycle 9 Bicycle
2. Were you the 9 driver 9 passenger
3. Were you in the 9 front 9 rear
4. Were you in the 9 right 9 left or 9 middle seat
5. Did the other vehicle strike your vehicle 9 yes 9 no
6. Did your vehicle strike the other vehicle 9 yes 9 no
7. My vehicle was 9 at a stop 9 at a stop with foot on brake 9 moving 9 slowing down
8. Were you struck on the 9 front 9 rear 9 right or 9 left 9 side of car 9 right or 9 left
9. Were you pushed into the other vehicle(s) 9 yes 9 no; Describe ___________________________________

   ____
10. How many impacts did you feel? ____
11. Was damage to your vehicle 9 slight 9 moderate 9 severe 9 total
12. At the time of the impact were you:
    - 9 Prepared for the crash/braced for the impact
    - 9 Unprepared for the crash/not braced for the impact
    - 9 Holding onto the steering wheel tightly
    - 9 Leaning on the arm rest
    - 9 Stepping hard on the brakes
13. At the time of the impact did any of the following occur?
    - 9 I felt a forceful jolt and/or jarring
    - 9 My body was thrown forward and backward
    - 9 My head and neck were thrown abruptly forward and backward
    - 9 My body was thrown sideways
    - 9 My head and neck were thrown abruptly sideways
14. Were you wearing a seatbelt at the time of the accident? 9 yes 9 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
Forehead 9 Middle Part 9 Left Side 9 Right Side			* **Steering Wheel**
Face 9 Cheeks 9 Nose 9 Mouth 9 Lips 9 Jaw			* **Dashboard**
Head 9 Left Side 9 Right Side 9 Top of Head 9 Back of Head			* **Door Glass/Window**
Arm 9 Right 9 Left	**Elbow** 9 Right 9 Left	**Forearm** 9 Right 9 Left	* **Door Arm Rest**
Hand 9 Right 9 Left	**Wrist** 9 Right 9 Left	**Shoulder** 9 Right 9 Left	* **Passenger-side Door**
Thigh 9 Right 9 Left	**Knee** 9 Right 9 Left	**Leg** 9 Right 9 Left	* **Driver-side Door**
Foot 9 Right 9 Left	**Ankle** 9 Right 9 Left	**Hip** 9 Right 9 Left	* **Gas, Clutch, Brake Pedal**
Spine 9 Upper 9 Middle 9 Lower			* **Gear Box**
Pelvis 9 Right 9 Left	Sacroiliac Joint 9 Right 9 Left		* **Roof of Car**
Ribs 9 Front 9 Back 9 Right Side 9 Left Side			* **Not Certain**

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16. Any other injuries to your body not listed? ____

____

17. Was the windshield broken on impact? 9 yes 9 no

18. Following the impact did you? 9 Faint 9 Blackout 9 Partially lose consciously momentarily

19. Do you have a clear memory of the accident? 9 yes 9 no

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

9 Nervous	9 Nauseated	9 Jittery
9 Stunned	9 Vomiting	9 Panicky
9 Confused	9 Lightheaded	9 Crying
9 Scared	9 Dizzy	9 Hysterical
9 Shocked	9 Dazed	

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

9 At the scene of the accident	9 Immediately following the accident
9 During the next several hours following the accident	9 The next morning
9 The next few days	9 Gradually over the next several weeks

22. What were your symptoms following the accident?

9 Headache	9 Neck pain and/or stiffness	
9 Mid-back pain and/or stiffness	9 Low-back pain and/or stiffness	
9 Upper back pain and/or stiffness		
Shoulder pain and/or stiffness	9 Right	9 Left
Arm pain and/or stiffness	9 Right	9 Left
Hip pain and/or stiffness	9 Right	9 Left
Leg pain and/or stiffness	9 Right	9 Left
Knee pain and/or stiffness	9 Right	9 Left
Ankle/foot pain and/or stiffness	9 Right	9 Left
Jaw/TMJ pain and/or stiffness	9 Right	9 Left

23. Were you able to get out of the vehicle yourself? 9 yes 9 no If not, were you assisted by:

9 paramedics 9 police 9 fire department 9 bystander 9 other ______________________________

24. Following the accident did you go: 9 home 9 work 9 emergency room 9 ______________________

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).

____

____

____

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

____

____

27. Since the accident are you: 9 Improved 9 Unchanged 9 Getting worse
    9 Improved however, some problems are not resolving

28. Prior to the accident, have you ever had previous accident(s) which required medical care? 9 yes 9 no

29. What type of accident(s)? 9 auto accident 9 work related accident 9 slip and fall injury

    What year(s)? ____

30. What major area(s) of your body was injured in previous accident(s)? 9 Head 9 Neck 9 Upper back
    9 Middle back 9 Lower back 9 Arms/hands 9 Legs/feet 9 Jaw/TMJ

31. Did you fully recover from the injuries sustained in the previous accident(s)? 9 yes 9 no

32. Have you ever had any serious illnesses that required hospitalization? 9 yes 9 no If yes, describe:

____

____

____

33. Have you had any nervous or mental illnesses? 9 yes 9 no

34. Have you had psychiatric care? 9 yes 9 no

35. Have you received a medical discharge from the armed forces? 9 yes 9 no

36. Have you returned to work since this accident? 9 yes 9 no If yes, have returned to work since your accident, please indicate which of the following statements below best describes your situation.

    9 Part time only due to injuries 9 Full time work is only type available

    9 Light duty due to accident injuries 9 Regular duty is only type work available

    Work increases severity of symptoms: 9 mildly 9 moderately 9 severely

CURRENT MEDICAL COMPLAINTS

BACK PAIN

37. Currently, I have pain in my: 9 Low back 9 Mid back 9 Upper back

38. Currently, I have stiffness in my: 9 Low back 9 Mid back 9 Upper back

39. My pain began after the accident: 9 yes 9 no

40. I have pain: 9 Sometimes (25%) 9 Half the time (50%) 9 Most of the time (75%) 9 All of the time (100%)

41. I have tingling and/or numbness in my: 9 Right leg 9 Left leg 9 Both

42. My pain is worse when I:

    Cough or Sneeze 9 yes 9 no Sit 9 yes 9 no Bend 9 yes 9 no

    Walk 9 yes 9 no Lift 9 yes 9 no Push 9 yes 9 no

    Pull 9 yes 9 no Stand 9 yes 9 no Lay down 9 yes 9 no

43. My back is worse with daily activity 9 yes 9 no

44. My pain wakes me up during the night 9 yes 9 no

45. Changes in the weather affect my pain 9 yes 9 no

NECK PAIN

46. My neck pain began after the accident? 9 yes 9 no

47. I have pain: 9 Sometimes (25%) 9 Half the time (50%) 9 Most of the time (75%) 9 All of the time (100%)

48. I have stiffness: 9 Sometimes (25%) 9 Half the time (50%) 9 Most of the time (75%) 9 All of the time (100%)

49. My pain goes into my: 9 Right arm 9 Left arm 9 Both

50. I have tingling and/or numbness in my: 9 Right arm 9 Left arm 9 Both

51. My pain is worse when I:

    Cough or Sneeze 9 yes 9 no   Turn head 9 yes 9 no   Bend 9 yes 9 no

    Lift 9 yes 9 no   Pull 9 yes 9 no   Push 9 yes 9 no

52. My pain wakes me up during the night. 9 yes 9 no

53. Changes in the weather affect my pain. 9 yes 9 no

54. I have headaches. 9 yes 9 no If yes, I get headaches, they occur:

    9 Sometimes (25%) 9 Half the time (50%) 9 Most of the time (75%) 9 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.

____

____

____

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

Stand	1	2	3	4	5	6	7	8	hours

Walk	1	2	3	4	5	6	7	8	hours

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)
9 Sometimes (25%) 9 Half the time (50%) 9 Most of the time (75%) 9 All of the time (100%)

58. Do you perform daily job activities involving repetitive use of any part of your body?
9 Sometimes (25%) 9 Half the time (50%) 9 Most of the time (75%) 9 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? 9 yes 9 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 __________________________________