VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed?_____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE
(if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

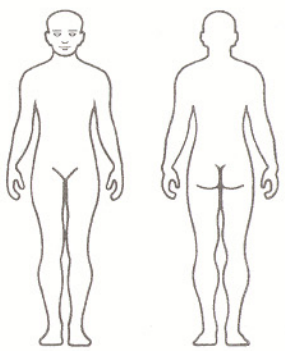
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

- ☐ Arm/shoulder pain
- ☐ Back pain
- ☐ Back stiffness
- ☐ Chest pain
- ☐ Dizziness
- ☐ Ear buzzing
- ☐ Ear ringing
- ☐ Fatigue
- ☐ Feet/toe numbness
- ☐ Hand/finger numbness
- ☐ Headaches
- ☐ Irritability
- ☐ Jaw problems
- ☐ Leg pain
- ☐ Memory loss
- ☐ Nausea
- ☐ Neck pain
- ☐ Neck stiff
- ☐ Shortness of breath
- ☐ Sleep difficulty
- ☐ Stomach upset
- ☐ Tension
- ☐ Vision blurred

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

I certify that the above information is correct to the best of my knowledge.

Patient Signature_____ Date_____

MOVE WELL CHIROPRACTIC

CHIROPRACTIC • REHAB • MASSAGE

Dr. David Oliver

HEALTH BENEFIT AFFIDAVIT

In accordance with chapter 273 of the Acts of 1988, we are required to obtain information regarding other health benefits (HMO, Medicare, Health insurance, etc.) available to you before we can process your claim for Personal Injury benefits (P.I.P).

Any medical expense in excess of $2,000.00 will not be paid under P.I.P., if those expenses will be compensated, paid or indemnified by an outside insurance carrier, (HMO, Medicare, Health insurance, etc.). Bills submitted for payment over $2,000.00 limit must be accompanied by a statement from your health carrier as to their reason for non-payment.

If you have other benefits available to you, please complete Section I. In addition, if you have benefits available to you through any other policy (spouse, parent, legal guardian), please be sure to complete Section II as well. If you do not have any benefits available through of your own insurance or those of a household member, please sign Section III.

SECTION I: Benefits Information

Your Name: _____
Health Insurance Company: _____
Policy Number: _____
Policyholder (if not your policy): _____
Date: _____ Signature: _____

SECTION II: Additional Benefits Information

Health Insurance Company: _____
Name of Policyholder: _____
Relationship: _____ Policy Number: _____
Date: _____ Signature: _____

SECTION III: No Benefits

I certify that I do not have any accident and/or health benefits available to me through my own policy or that of a household member.

Date: _____ Signature: _____

MOVE WELL CHIROPRACTIC

CHIROPRACTIC • REHAB • MASSAGE

PIP (Personal Injury Protection) Insurance Information

Move Well Chiropractic
1280 Centre St. Ste. 210
Newton, Ma 02459

Name _____ DOB: ___/___/_____

Auto Insurance _____

Auto Insurance address _____

_____

Auto Insurance Phone # _____

Claim # _____

Adjuster _____

Attorney (if applicable) _____

Attorney address _____

Attorney Phone # _____

Do we have a copy of your Medical Insurance Card? _____

ID# _____

Were you on work time at the time of your accident? YES NO

Have you been to another Chiropractic Physician or physical therapist as result of your accident prior to this appointment? YES NO

Have you been to an independent medical examination deemed necessary by your insurance company? YES NO

Please Read: This questionnaire is designed to enable us to understand how much your **Neck pain** has affected your ability to manage 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 closely describes your problem *right now*.**

SECTION 1--Pain Intensity

A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 -- Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving

A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping

A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation

A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all all.

SIGNATURE:_____ **DATE:**_____

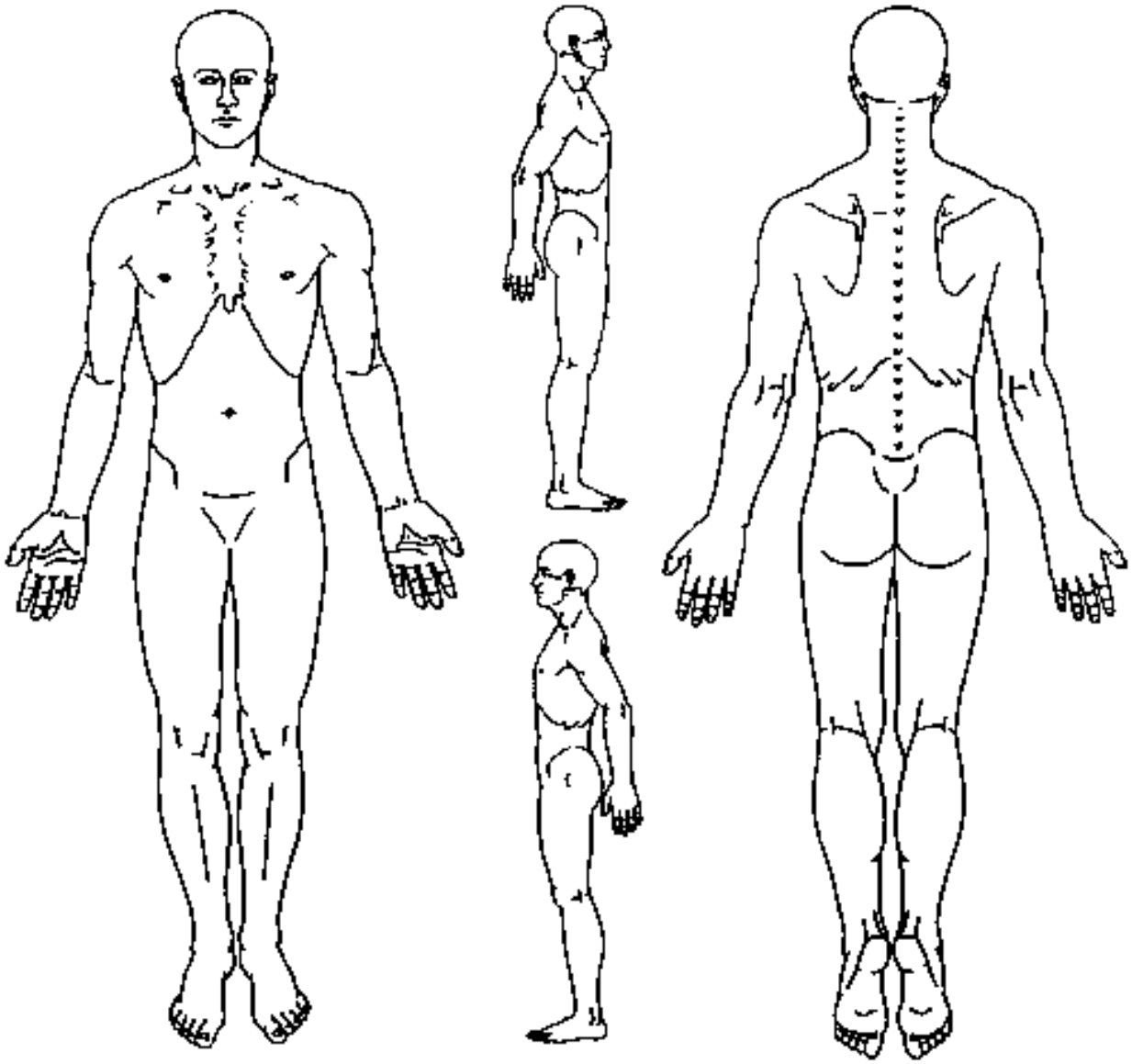
DISABILITY INDEX SCORE: _____**%**

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. (Use description letters from below) Please complete both sides of this form.



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

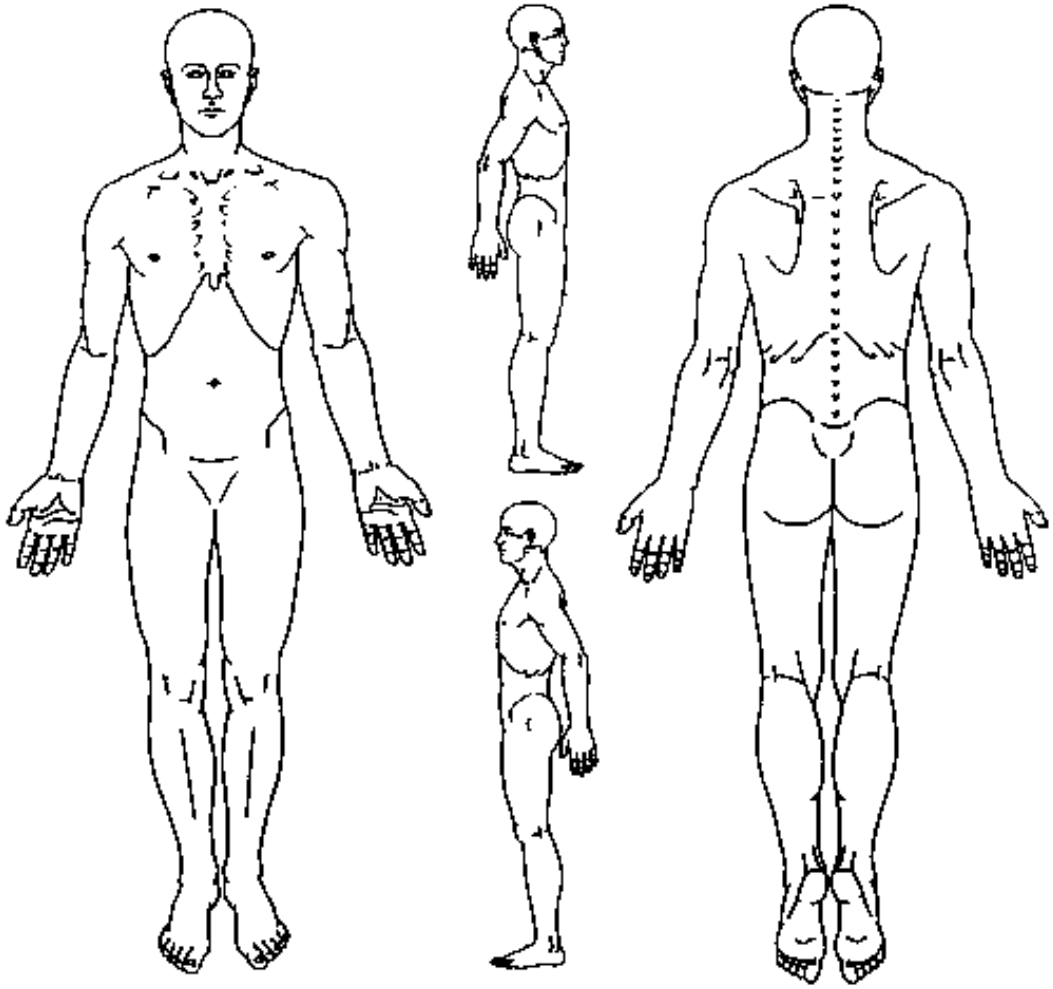
OVER PLEASE ⇒

THE REVISED OWESTRY PAIN QUESTIONNAIRE

Name_____ Date_____

How long have you had back pain _____years ____months____ weeks____

On the diagram below, please indicate where you are experiencing pain, right now. (Use description letters from below) Please complete both side of this form.



A= ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S** = STABBING	**O** = OTHER (please write in sensation)

OVER PLEASE

Please Read: This questionnaire is designed to enable us to understand how much your **Low Back pain** has affected your ability to manage 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 closely describes your problem *right now*.**

SECTION 1- Pain Intensity
A. The pain comes and goes and is very mild
B. The pain is mild and does not vary much
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much
E. The pain is severe but comes and goes
F. The pain is severe and does not vary much

SECTION 2- Personal Care
A. I would not have to change the way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing when though it causes some pain.
C. Washing and dressing increases pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3- Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor, but I can mange if they are conveniently positioned .e.g. on the table
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can only lift very light weights, at the most
F. I cannon lift or carry anything.

SECTION 4- Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than ½ mile
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk while using a cane or crutches.
F. I can not walk at all without increasing pain.

SECTION 5- Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than 1 hour,
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

SECTION 6- Standing
A. I can stand as long as I want without pain
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannon stand for longer than ½ hr without increasing pain.
E. I can't stand for more than 10 min without increasing pain.
F I avoid standing because it increases pain right away.

SECTION 7- Sleeping
A. I get not pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain, my normal night's sleep is reduced by less than ¼.
D. Because of pain, my normal night's sleep is reduced by less than ½.
E. Because of pain, my normal night's sleep is reduced by less than ¾.
F. Pain prevents me from sleeping at all.

SECTION 8- Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of my pain

SECTION 9- Traveling.
A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain restricts all forms of travel.

SECTION 10- Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates , but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting worse or better.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

SIGNATURE:_____ **DATE:**_____

DISABILITY INDEX SCORE: %