Dominion Chiropractic Clinic **Motor Vehicle Collision Questionnaire**

Patient Name:_____ Date_____
Cell Phone _____ Home Phone _____ Work Phone_____

Address _____ City_____ State_____ Zip_____

Email Address_____

Sex ☐M ☐F Marital Status ☐M ☐S ☐D ☐W Date of Birth_____ Age _____

Social Security Number_____ Occupation_____ Employer _____

Have you ever received chiropractic care? ☐Yes ☐No If yes, when? _____ Name of most recent chiropractor? _____

1. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

_____

_____

2. **Since the motor vehicle collision, have you experienced any of the following:**
   - **a.** Loss of range of motion: ☐ yes ☐ no
     If yes, please explain _____
   - **b.** Visual disturbance: ☐ yes ☐ no
     ☐BLURRING L/R __% of time ☐FLOATERS L/R __% of time ☐VISION LOSS L/R __% of time ☐HYPERSENSITIVITY L/R __% of time
   - **c.** Dizziness: ☐ yes ☐ no __% of time
   - **d.** Anxiety: ☐ yes ☐ no __% of time
   - **e.** Depression: ☐ yes ☐ no __% of time
   - **f.** Difficulty sleeping: ☐ yes ☐ no __% of time
3. **Past health history:**
   - **a.** Please indicate if you have a history of any of the following:
     ☐anticoagulant use ☐heart problems/high blood pressure/chest pain ☐bleeding problems ☐lung problems/shortness of breath
     ☐cancer ☐diabetes ☐psychiatric disorders ☐bipolar disorder ☐major depression ☐schizophrenia ☐stroke/TIA's
     ☐other _____ ☐none of the above
   - **b.** Previous Trauma or injury _____
     Have you ever broken any bones? Which? _____
   - **c.** Allergies: _____
   - **d.** Medications/reason for taking: _____
     _____
   - **e.** Surgeries/type of surgery/dates: _____
     _____
   - **f.** Females/Pregnancies/Dates/Outcomes: _____
     _____
4. **Family Health History**
   Do you have a family history of? (Please indicate all that apply)
   ☐cancer ☐strokes/TIA's ☐headaches ☐cardiac disease ☐neurological diseases ☐ adopted/unknown
   ☐cardiac disease below age 40 ☐psychiatric disease ☐diabetes ☐other _____ ☐none of the above
   Deaths in immediate family (relationship, date, age, cause):
   _____
5. **Social and Occupational History**
   - **a.** Job Description_____
   - **b.** Work Schedule_____
   - **c.** Recreational Activities_____
   - **d.** Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet)
     _____

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Review of Systems Name _____ Date _____

Have you had any of the following **pulmonary (lung-related)** issues?

☐ Asthma/difficulty breathing ☐ COPD ☐ Emphysema ☐Other _____ ☐ N/A

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

☐ Heart surgeries ☐ Congestive heart failure ☐ Murmurs or valvular disease ☐ Heart attacks/MIs ☐ Heart disease/problems ☐ Hypertension ☐ Pacemaker ☐ Angina/chest pain ☐ Irregular heartbeat ☐ Other _____ ☐ N/A

Have you had any of the following **neurological (nerve-related)** issues?

☐ Visual changes/loss of vision ☐ One-sided weakness of face or body ☐ History of seizures ☐ One-sided decreased feeling in the face or body ☐ Headaches ☐ Memory loss ☐ Tremors ☐ Vertigo ☐ Loss of sense of smell ☐ Strokes/TIAs ☐ Other _____ ☐ N/A

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

☐ Thyroid disease ☐ Hormone replacement therapy ☐ Injectable steroid replacements ☐ Diabetes ☐ Other _____ ☐ N/A

Have you had any of the following **renal (kidney-related)** issues or procedures?

☐ Renal calculi/stones ☐ Hematuria (blood in the urine) ☐ Incontinence (can't control) ☐ Bladder infections ☐ Difficulty urinating ☐ Kidney disease ☐ Dialysis ☐ Other_____ ☐ N/A

Have you had any of the following **gastroenterological (stomach-related)** issues?

☐ Nausea ☐ Difficulty swallowing ☐ Ulcerative disease ☐Frequent abdominal pain ☐ Hiatal hernia ☐ Constipation ☐ Pancreatic disease ☐ Irritable bowel/colitis ☐ Hepatitis or liver disease ☐ Bloody or black tarry stools ☐ Vomiting blood ☐ Bowel incontinence ☐ Gastroesophageal reflux/heartburn ☐ Other _____ ☐ N/A

Have you had any of the following **hematological (blood related)** issues?

☐ Anemia ☐ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) ☐ HIV positive ☐ Abnormal bleeding/bruising ☐ Sickle-cell anemia ☐ Enlarged lymph nodes ☐ Hemophilia ☐ Hypercoagulation or deep venous thrombosis/history of blood clots ☐ Anticoagulant therapy ☐ Regular aspirin use ☐ Other _____ ☐ N/A

Have you had any of the following **dermatological (skin-related)** issues?

☐ Significant burns ☐Significant rashes ☐ Skin grafts ☐ Psoriatic disorders ☐ Other_____ ☐ N/A

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

☐ Rheumatoid arthritis ☐ Gout ☐ Osteoarthritis ☐ Broken Bones ☐ Spinal fracture ☐ Spinal surgery ☐ Joint surgery ☐ Arthritis (unknown type) ☐ Scoliosis ☐ Metal Implants ☐Other _____ ☐ N/A

Have you had any of the following **psychological** issues?

☐ Psychiatric diagnosis ☐ Depression ☐ Suicidal ideations ☐Bipolar disorder ☐Homicidal ideations ☐ Schizophrenia ☐ Psychiatric hospitalizations ☐ Other _____ ☐ N/A

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Dominion Chiropractic Clinic for services performed. I also understand that I am personally responsible for any and all charges which are incurred as a result of my care at this office.

Patient/Guardian signature _____ Date_____

Patient Name _____ Date_____

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Dominion Chiropractic Clinic **Motor Vehicle Collision Questionnaire**

New Patient History Form

Please list your primary complaint for symptom 1. If you have a secondary complaint to address, use symptom 2.

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time
  0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time that you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Was this symptom a result of a motor vehicle collision? ☐Yes ☐No
  - Did you have this symptom before this motor vehicle collision? ☐Yes ☐No
    If so, what was the intensity (1-10) and frequency? _____
- What makes the symptom worse?☐Bending neck forward ☐bending neck backward ☐tilting head to left ☐tilting head to right ☐turning head to left ☐turning head to right ☐bending forward at waist ☐bending backward at waist ☐tilting left at waist ☐tilting right at waist ☐twisting left at waist ☐twisting right at waist ☐sitting ☐standing ☐getting up from seated position ☐lifting ☐any movement ☐driving ☐walking ☐running ☐nothing ☐other _____
- What makes the symptom better? ☐rest ☐ice ☐heat ☐stretching ☐exercise ☐massage ☐pain medication ☐muscle relaxers ☐nothing ☐other _____
- Describe the quality of the symptom: ☐sharp ☐dull ☐achy ☐burning ☐throbbing ☐piercing ☐stabbing ☐deep ☐nagging ☐shooting ☐stinging ☐other _____
- Does the symptom radiate to another part of your body? ☐No ☐Yes If yes, where _____
- Is the symptom worse at certain times of the day or night? ☐morning ☐afternoon ☐evening ☐night ☐unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time
  0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time that you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Was this symptom a result of a motor vehicle collision? ☐Yes ☐No
  - Did you have this symptom before this motor vehicle collision? ☐Yes ☐No
    If so, what was the intensity (1-10) and frequency? _____
- What makes the symptom worse?☐Bending neck forward ☐bending neck backward ☐tilting head to left ☐tilting head to right ☐turning head to left ☐turning head to right ☐bending forward at waist ☐bending backward at waist ☐tilting left at waist ☐tilting right at waist ☐twisting left at waist ☐twisting right at waist ☐sitting ☐standing ☐getting up from seated position ☐lifting ☐any movement ☐driving ☐walking ☐running ☐nothing ☐other _____
- What makes the symptom better? ☐rest ☐ice ☐heat ☐stretching ☐exercise ☐massage ☐pain medication ☐muscle relaxers ☐nothing ☐other _____
- Describe the quality of the symptom: ☐sharp ☐dull ☐achy ☐burning ☐throbbing ☐piercing ☐stabbing ☐deep ☐nagging ☐shooting ☐stinging ☐other _____
- Does the symptom radiate to another part of your body? ☐No ☐Yes If yes, where _____
- Is the symptom worse at certain times of the day or night? ☐morning ☐afternoon ☐evening ☐night ☐unaffected by time of day

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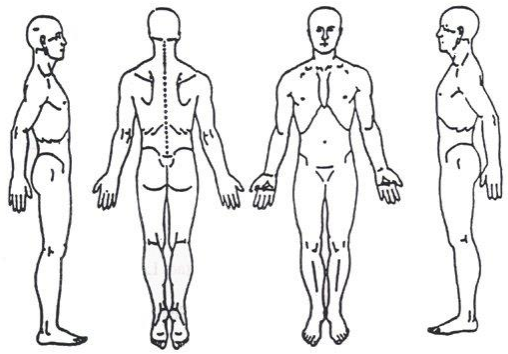
Name _____ Date_____

Functional Rating Index

To properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1.	**Pain Intensity**	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
2.	**Sleeping**	0 Perfect sleep	1 Mildly disturbed sleep	2 Moderately disturbed sleep	3 Greatly disturbed sleep	4 Totally disturbed sleep
3.	**Personal Care** (washing, dressing, etc)	0 No pain; no restrictions	1 Mild pain; no restrictions	2 Moderate pain; need to go slowly	3 Moderate pain; need some assistance	4 Severe pain; need 100% assistance
4.	**Travel** (driving, etc)	0 No pain on long trips	1 Mild pain on long trips	2 Moderate pain on long trips	3 Moderate pain on short trips	4 Severe pain on short trips
5.	**Work**	0 Can do usual work plus unlimited extra work	1 Can do usual work with no extra work	2 Can do 50% of usual work	3 Can do 25% of usual work	4 Cannot work
6.	**Recreation**	0 Can do all activities	1 Can do most activities	2 Can do some activities	3 Can do a few activities	4 Cannot do any activities
7.	**Frequency of pain**	0 No pain	1 Occasional pain 25% of the day	2 Intermittent pain 50% of the day	3 Frequent pain 75% of the day	4 Constant pain 100% of the day
8.	**Lifting**	0 No pain with heavy weight	1 Increased pain with heavy weight	2 Increased pain with moderate weight	3 Increased pain with light weight	4 Increased pain with any weight
9.	**Walking**	0 No pain any distance	1 Increased pain after 1 mile	2 Increased pain after ½ mile	3 Increased pain after ¼ mile	4 Increased pain with all walking
10.	**Standing**	0 No pain after several hours	1 Increased pain after several hours	2 Increased pain after 1 hour	3 Increased pain after ½ hour	4 Increased pain with any standing

Patient's signature_____ Date_____



Please indicate problem areas on the chart

(pain- XXX, numbness- NNN, tingling- TTT)

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AUTO ACCIDENT MECHANISM OF INJURY FORM

Name _____ Today's date_____

Please describe how the collision happened: _____

_____

_____

_____

What was your position in the car? ☐Driver ☐Front passenger ☐Left rear ☐Right rear

If "driver," were your hands on the steering wheel? ☐Both ☐Left ☐Right

Did the airbags deploy? ☐Yes ☐No

Did you strike another vehicle? ☐Yes ☐No

Angle of impact: ☐Front ☐Back ☐Left ☐Right ☐Other: _____

If second collision- Second angle of impact: ☐Front ☐Back ☐Left ☐Right ☐Other: _____

In relation to the back of your head, how was your headrest set: ☐Low ☐Middle ☐High

Were you surprised by the impact? ☐Yes ☐No If no, how did you brace? ☐With hands ☐With feet

Where was your head facing at the time of impact? ☐Straight ahead ☐Left ☐Right ☐Behind

Were you leaning forward at the time of impact? ☐Yes ☐No

What type and year of vehicle were you in? _____

What was the approximate speed of your vehicle when the accident occurred? _____ mph

What type and year of vehicle struck yours? _____

What was the approximate speed of the other vehicle when the accident occurred? _____ mph

Were you wearing a seatbelt? ☐Yes ☐No What type? ☐Lap belt ☐Shoulder belt ☐Both

Did you feel pain immediately after the accident? ☐Yes ☐No

Were you rendered unconscious as a result of the accident? ☐Yes ☐No

Did you strike anything in the vehicle at the time of impact? ☐Yes ☐No
If yes, specify what part of your body struck what (i.e. head, chest, chin, shoulder, knee, etc.)

☐Steering wheel _____ ☐Windshield _____ ☐Dashboard _____

☐Roof _____ ☐Left side door _____ ☐Right side door _____

☐Left window _____ ☐Right window _____ ☐Other _____

Did your seat break or bend? ☐Yes ☐No

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Immediately following the accident, how did you feel?
☐Dizzy ☐Dazed ☐Weak ☐Upset ☐Disoriented ☐Nervous ☐Nauseous ☐Other _____

POLICE AND AMBULANCE:
Was the accident reported to the police? ☐Yes ☐No

Were traffic citations issued? ☐Yes ☐No If yes, to whom? _____

Did you to go the hospital? ☐Yes ☐No If yes, how did you get there? ☐Ambulance ☐Police car ☐Private transportation
Were you admitted? ☐Yes ☐No If yes, how long? _____
Name of hospital _____ Attended by Dr. _____

What treatment was given? ☐None ☐X-rays ☐Pain medication ☐Stitches ☐Muscle relaxants ☐Bandages ☐Cervical collar
☐Physical therapy ☐Instructed regarding concussion ☐Instructed regarding sprains & strains ☐Instructed to call an orthopedist
☐Instructed to call a private physician ☐Referred to this office ☐Other _____

What other doctor have you seen as a result of this injury?
_____

Do you have difficulty in excessive: ☐Standing ☐Walking ☐Riding ☐Bending ☐Twisting
Do you have difficulty in excessive lifting: ☐Light ☐Moderate ☐Heavy ☐Repetitive
Symptoms other than above:
_____

INSURANCE INFORMATION

Your car insurance company _____ Agent name _____

Policy number _____ Claim number _____

Claims agent _____ Phone number _____

Billing address _____

Driver of other vehicle _____ Their insurance company _____

Agent name _____ Policy number _____

Claim number _____ Phone number _____

Billing address _____ Have you retained an attorney? ☐Yes ☐No

Attorney name _____ Phone number _____

Attorney address _____

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

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