Motor Vehicle Accident Injury Information

Name: _____ Date of Accident: _____

Time it occurred: _____ Was the accident your fault? _____

Place: (intersection/city/state) _____

Please describe, to the best of your knowledge, what happened during this accident: _____

_____

_____

Road conditions at time of accident: _____Wet _____Dry _____ Icy

Where were you seated in the vehicle? _____

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? _____

_____

Where was the vehicle impacted? _____Rear end _____ Front _____Left side _____ Right side

How far is the top of the headrest from the top of your head? _____

Were you wearing a shoulder and lap seatbelt? _____

Is your car equipped with an airbag? _____ Did it activate? _____

Was your vehicle stopped at the time of impact? _____

If yes, was the drivers foot on the _____ brake? _____ clutch?

If no, then estimate the speed of the vehicle you were in: _____ mph

Number of people in the vehicle: _____ What type of car were you in? _____

What type of car impacted with you? _____

Was the other vehicle moving at the time of impact? _____ How fast? _____ mph

What bruises or cuts did you get from the accident? _____

Did any of your body parts hit any part of the car? (ie your head on the dash, your shoulder on the door, etc.)

_____

What position was your head facing upon impact? _____

After the initial impact, did your car hit anything else? _____

Did pain begin _____ suddenly after trauma or _____ gradually after trauma

Are the symptoms worse at certain times of the day? _____ If so, when is it worse? _____

- When does it feel better? _____ What do you do to make yourself feel better? _____

_____

The pain is: _____ constant, never leaves, and disrupts daily activities, including sleep.

_____ comes and goes and lasts for _____minutes _____hours _____ days at a time.

What activities make your pain/symptoms worse? _____

_____

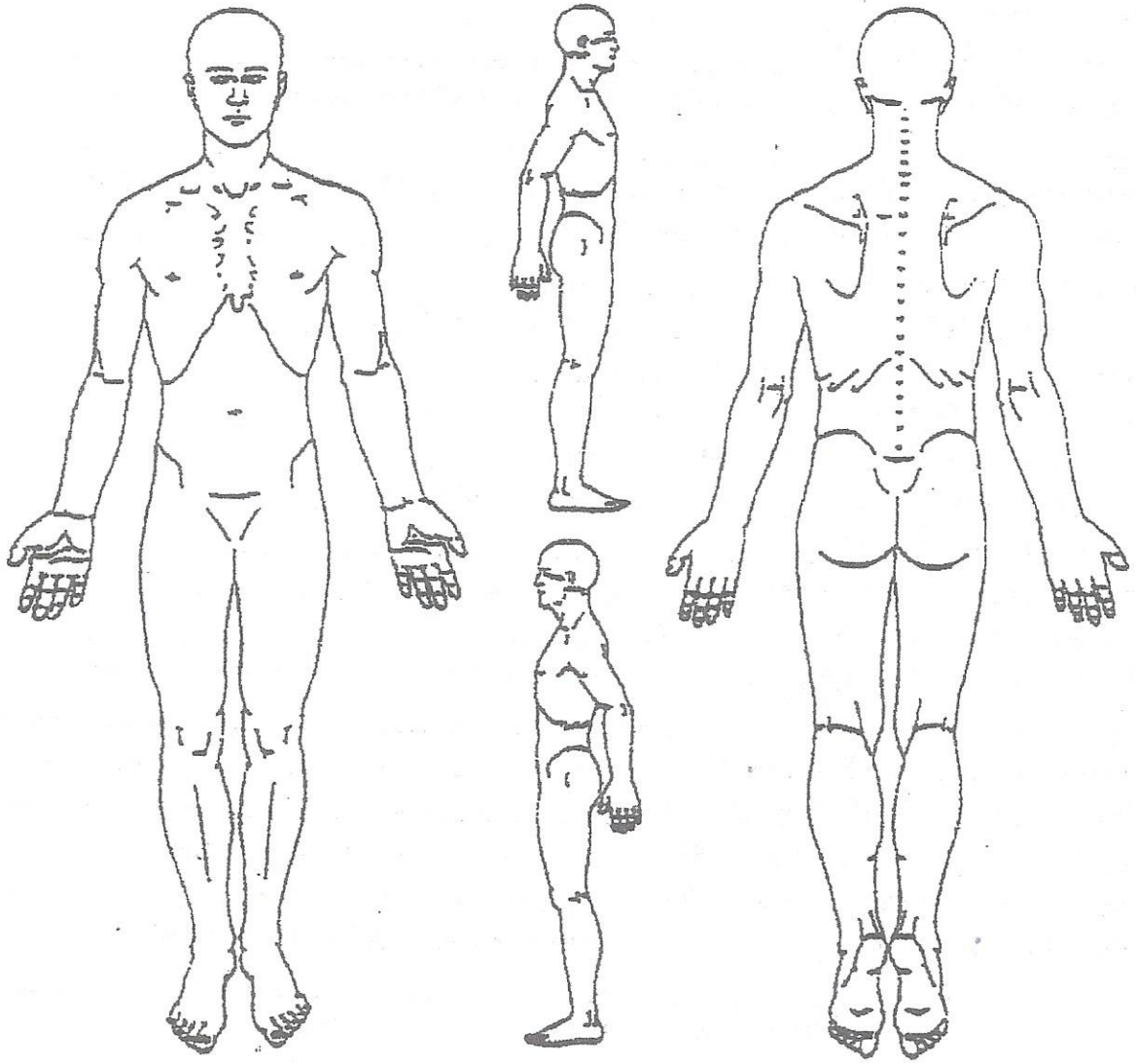
What activities make your pain/symptoms better? _____

_____

Please turn over

On the figures below, use the indicated marks to show areas where you have experienced:

Pain O	Spasm ≈≈	Weakness W
Numbness N	Tension ≡	Throbbing T
Tingling zzz	Ache A	Burning ✳



Patient Signature: _____ Today's date: _____

FUNCTIONAL RATING INDEX

Name: _____ Date: _____

In order to properly assess your condition, we must understand how much your symptoms have affected your ability to manage everyday activities. For each item below, please indicate the number which most closely describes your condition right now. At the end of the current treatment schedule, we will reassess the functional limitations.

Area being assessed: (Circle one) Neck R / L : Shoulder Upper Back Mid Back Low Back
Other: _____

A. Pain Intensity: _____

0= No Pain | 1= Mild pain | 2= Moderate pain | 3= Severe pain | 4= Worst possible pain

B. 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

C. Sleeping: _____

0 = Perfect sleep | 1= Mildly disturbed | 2= Moderately disturbed | 3= Greatly disturbed | 4= Totally disturbed

D. Personal Care (washing/showering, 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

E. 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 trip | 4= Severe pain on short trips

F. Work: _____

0= Can do usual work | 1= Can slowly do usual work | 2= Can do 50% of usual work | 3= Can do light duty work | 4= Can not work

G. 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

H. Walking: _____

0= No pain any distance | 1= Increased pain after 1 mile | 2= Increased pain after 1/2 mile | 3= Increased pain after 1/4 mile | 4= Increased pain with any walking

I. Standing: _____

0= No pain after several hours | 1= Increased pain after several hours | 2= Increased pain after 1 hour | 3= Increased pain after 1/2 hour | 4= Increased pain with any standing