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COLORADO BOULEVARD CHIROPRACTIC CENTER

NAME:_____ PHONE #:_____ DATE:_____
DATE OF ACCIDENT:_____ TIME OF ACCIDENT:_____AM PM
CITY OF ACCIDENT:_____ STREET OF ACCIDENT:_____
ROAD CONDITIONS AT THE TIME OF THE ACCIDENT: wet--dry--icy--other
DID THE POLICE COME TO THE ACCIDENT SCENE?: _____. WERE YOU TAKEN TO A HOSPITAL?:_____. IF YES, WHAT WAS THE NAME OF THE HOSPITAL_____, & IN WHAT CITY IS IT?: _____.
HOW DID YOU GET TO THE HOSPITAL?:_____.
WHERE ANY X-RAYS TAKEN?:_____ WHICH PARTS WHERE X-RAYED?:_____.

THE FOLLOWING QUESTIONS PERTAIN TO YOU, THE PATIENT, AND THE VEHICLE YOU WHERE IN:

1. WHERE WERE YOU SEATED IN THE VEHICLE? _____.

2. WERE YOU AWARE OF THE APPROACHING COLLISION PRIOR TO IMPACT, OR DID IMPACT CATCH YOU BY SUPRISE? _____.

3. DID YOU LOSE CONCIOUSNESS (black out) UPON IMPACT? _____.

4. IF YOU DID LOSE CONSCIOUSNESS, ESTIMATE HOW LONG _____.

5. HOW FAR IS THE TOP OF THE HEADREST OR SEATBACK FROM THE TOP OF YOUR HEAD? (approximately) _____inches aboye -- below.

6. WERE YOU WEARING YOUR SEAT BELT? _____; IF "YES", THEN WAS IT A LAP SEAT BELT _____, OR A SHOULDER LAP SEAT BELT _____?

7. LIST THE YEAR, MAKE, AND MODEL OF THE VEHICLE YOU WERE IN:
YEAR_____: MAKE _____; MODEL _____.

8. WAS YOUR CAR STOPPED AT THE TIME OF IMPACT? _____ ; IF YES, THEN WAS THE DRIVER'S FOOT ALSO ON THE BRAKE? _____; IF NO, THEN ESTIMATE THE SPEED OF THE VEHICLE YOU WERE IN _____ M.P.H..

9. IF THE VEHICLE WAS MOVING AT THE TIME OF IMPACT, WAS IT SLOWING DOWN _____; OR WAS IT GAINING SPEED_____.

10. PLEASE DESCRIBE TO THE BEST OF YOUR KNOWLEDGE, WHAT HAPPENED DURING THIS ACCIDENT: _____

_____

_____

11. WHAT BLEEDING CUTS DID YOU GET DURING THE ACCIDENT? _____

_____

12. WHAT BRUISES DID YOU GET DURING THE ACCIDENT? _____

_____

13. ON WHAT PART OF THE VEHICLE DID THE FOLLOWING BODY PARTS HIT.

A. HEAD HIT:
B. CHEST HIT:
C. RT.-LT. SHOULDER HIT:
D. RT.- LT. ARM HIT:
E. RT.-LT. HIP HIT:
F. RT.-LT. LEG HIT:
G. RT.-LT. KNEE HIT:
H. OTHER:

14. WHAT IS THE DAMAGE COST OF THE VEHICLE YOU WERE IN?_____

15. WHAT OF THE FOLLOWING CAR PARTS BROKE DURING THE ACCIDENT?

A. WINDSHIELD B. RT.-LT. SIDE WINDOW C. STEERING WHEEL
D. FRONT OR BACK SEAT E. OTHER_____

16. WAS THE TRUNK OF YOUR BODY POINTED STRAIGHT FORWARD AT THE TIME OF COLLISION?_____. IF "NO", WHICH DIRECTION WAS IT TURNED, AND BY HOW MUCH? _____

17. WAS YOUR HEAD POINTED STRAIGHT FORWARD?_____ IF "NO", WHAT DIRECTION WAS IT TURNED, AND BY HOW MUCH? _____

THE FOLLOWING QUESTIONS PERTAIN TO THE OTHER VEHICLE INVOLVED IN THE ACCIDENT.

1. WHAT IS THE YEAR, MAKE AND MODEL OF THE OTHER CAR?
   YEAR _____; MAKE _____; MODEL _____
2. WAS THE OTHER VEHICLE MOVING AT THE TIME OF COLLISION? _____
   IF YES, WHAT WAS ITS APPROXIMATE SPEED? _____M.P.H.
3. IF THE OTHER VEHICLE WAS MOVING AT THE TIME OF COLLISION, WAS IT SLOWING DOWN? _____; GAINING SPEED? _____; OR TRAVELING AT A STEADY SPEED? _____.

IF YOU HAVE BEEN IN PREVIOUS AUTO ACCIDENTS, PLEASE LIST THE YEAR EACH WAS IN:

1. _____
2. _____
3. _____
4. _____
5. _____

Colo. Blvd. Chiropractic Center
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PATIENTS ACCIDENT REPORT FOR SPINAL INJURIES

TODAYS DATE_____

Name:_____ Occupation:_____ Birth Date_____
Address_____ Phone: Bus._____ Res._____
Employer:_____ Business Address_____
Attorney:_____ Address_____
Phone_____ Insurance:_____
Referred by:_____
History of Present Injury: Date:_____ Approximate Time:_____(AM or PM)
On the Job Injury: (check one) _____yes _____no
If other than auto injury, give particulars of accident:

_____

_____

If auto injury please fill out the following information:
Patient's car was going: Direction_____Street or Road_____
Closest bisecting street (if any):_____(Town)_____
Number of motor vehicles involved in accident_____#of Persons:_____
Check if Patient was: _____moving _____stopped _____turning right____ or left____
Car was struck: in the rear_____ in front_____ right side _____ left side _____
Did you see the accident coming? Yes_____ No_____ Were seat belts worn? Y/N _____
Upon impact which way was your body thrown? Forward___ backward_____ left_____ right_____
Upon impact was there a binding or explosive sensation in the head?_____
State which areas of your body were hurt immediately after the accident?_____

Were you able to get out of the car and walk?_____
Were you conscious at all times?_____ Could you move all parts of your body?_____
Was a police report made?_____ Was a citation given?_____ If so, to whom?_____
Was an ambulance called?_____ Did you go to the hospital?_____
If so, what was done?(check) X-rays_____ Examination_____ Medications_____
If medications, what was there nature?_____
How long were you in the hospital?_____ From:_____ To:_____
Were you able to sleep that night?_____ What discomfort, if any?_____
What discomfort the next day?_____
The day after?_____
A week After:_____
From the time of the accident, have there been any of the following? If so please explain in the spaces provided below.

Eye complaint_____ Ear complaints_____ Facial disturbances_____
Difficulty in swallowing_____ Dizziness_____ Increased sweating_____ Nasal Disturbances_____ Chest pain or disturbances _____ Burning muscle pain _____ Lapses of consciousness_____ Headaches_____ Insomnia _____ Restlessness_____ Mood changes _____ Behavior Changes_____ Numbness of extremities_____
Tingling of the arms or legs_____ Coldness of hands or feet_____ Inability to urinate_____ Difficulty urinating_____ Loss of strength in the arms r legs_____
Difficulty moving arms or legs_____ Clumsiness_____
Please explain any of the above_____

_____

Other Symptoms?

Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday -life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present -day situation.

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. I wash with difficulty and stay in bed.

Section 3 – Lifting

0☐ I can lift heavy weights without causing 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 items are conveniently positioned, ie. on a table.
3☐ Pain prevents me from lifting heavy weights, but I can manage light 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 – Work

0☐ I can do as much work as I want.
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 can't do my usual work.
4☐ I can hardly do any work at all.
5☐ I can't do any work at all.

Section 5 – Headaches

0☐ I have no headaches at all.
1☐ I have slight headaches that come infrequently.
2☐ I have moderate headaches that come infrequently.
3☐ I have moderate headaches that come frequently.
4☐ I have severe headaches that come frequently.
5☐ I have headaches almost all the time.

Section 6 – Concentration

0☐ I can concentrate fully without difficulty.
1☐ I can concentrate fully with slight difficulty.
2☐ I have a fair degree of difficulty concentrating.
3☐ I have a lot of difficulty concentrating.
4☐ I have a great deal of difficulty concentrating.
5☐ I can't concentrate at all.

Section 7 – Sleeping

0☐ I have no trouble sleeping.
1☐ My sleep is slightly disturbed for less than 1 hour.
2☐ My sleep is mildly disturbed for up to 1-2 hours.
3☐ My sleep is moderately disturbed for up to 2-3 hours.
4☐ My sleep is greatly disturbed for up to 3-5 hours.
5☐ My sleep is completely disturbed for up to 5-7 hours.

Section 8 – Driving

0☐ I can drive my car without neck pain.
1☐ I can drive as long as I want with slight neck pain.
2☐ I can drive as long as I want with moderate neck pain.
3☐ I can't drive as long as I want because of moderate neck pain.
4☐ I can hardly drive at all because of severe neck pain.
5☐ I can't drive my care at all because of neck pain.

Section 9 – Reading

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

Section 10 – Recreation

0☐ I have no neck pain during all recreational activities.
1☐ I have some neck pain with all recreational activities.
2☐ I have some neck pain with a few recreational activities
3☐ I have neck pain with most recreational activities.
4☐ I can hardly do recreational activities due to neck pain.
5☐ I can't do any recreational activities due to neck pain.

Patient Name _____ Date _____

Score _____ [50] Benchmark -5 = _____

OSWESTRY INDEX QUESTIONNAIRE (LOWER BACK)

This questionnaire is designed to help us better understand how your back pain affects your ability to manage everyday -life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present -day situation.

SECTION 1 - PAIN INTENSITY

- ☐ My pain is mild to moderate. I do not need pain killers.
- ☐ The pain is bad, but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain.

SECTION 2 - PERSONAL CARE

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

SECTION 3 – LIFTING

- ☐ I can lift heavy weights without causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – WALKING

- ☐ I can walk as far as I wish.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can walk only if I use a cane or crutches.
- ☐ I am in bed or in a chair for most of every day.

SECTION 5 – SITTING

- ☐ I can sit in any chair for as long as I like.
- ☐ I can sit in my favorite chair only, but for as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

SECTION 6 – STANDING

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want, but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing more than 1/2 hour.
- ☐ Pain prevents me from standing more than 10 minutes
- ☐ Pain prevents me from standing at all.

SECTION 7 – SLEEPING

- ☐ Pain does not prevent me from sleeping well.
- ☐ I sleep well but only when taking medication.
- ☐ Even when I take medication, I sleep less than 6 hours.
- ☐ Even when I take medication, I sleep less than 4 hours.
- ☐ Even when I take medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ☐ Social life is normal and causes me no extra pain.
- ☐ Social life is normal, but increases the degree of pain.
- ☐ Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- ☐ Pain has restricted my social life, and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 9 - SEXUAL ACTIVITY

- ☐ Sexual activity is normal and causes no extra pain.
- ☐ Sexual activity is normal, but causes some extra pain.
- ☐ Sexual activity is nearly normal, but is very painful.
- ☐ Sexual activity is severely restricted by pain.
- ☐ Sexual activity is nearly absent because of pain.
- ☐ Pain prevents any sexual activity at all.

SECTION 10 – TRAVELING

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere, but it gives me extra pain.
- ☐ Pain is bad, but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to necessary journeys under ½ hr.
- ☐ Pain prevents traveling except to the doctor/hospital.

PATIENT NAME _____

SCORE _____ [50]

DATE _____