AGLA
Chiropractic
Ease for all ages & stages of life!

Claim#: _____
P.O. Box 23955, Federal Way, WA 98093
Phone: (253) 632-5320 Fax: (253) 214-7444
www.AGLAchiro.com

ACCIDENTAL INJURY FORM

Patient Name:_____ Today's Date:_____
Date of accident:_____ Hour:_____ AM/PM Location:_____
Type of accident: Work Related _____ Traffic Related_____ Other:_____
List all other health care practitioners seen for this injury?_____

WORK RELATED ACCIDENT: (Include full details, drawings, etc. on the reverse side)
Describe your accident including cause/s and surrounding circumstances below:
Employer:_____ Type of Business:_____
Street Address:_____
City:_____ State:_____ Zip:_____
Was accident reported to supervisor and/or employer? Yes _____ No _____ Name:_____
Has a worker's compensation claim been filed? Yes _____ No _____ Claim#:_____
Was any equipment, machinery, and/or object related to the accident? Yes _____ No _____ What Kind?_____
_____

TRAFFIC RELATED ACCIDENT: (Include full details, drawings, etc. on the reverse side)
Describe your accident including cause/s and surrounding circumstances below:
What kind of vehicles were involved? Yours:_____ Other(s):_____
Were you the: Driver _____ Passenger _____ Pedestrian _____? Were you wearing a seat belt? Yes _____ No _____
Was anyone else in the vehicle with you? Yes _____ No _____ Who?_____
Was your vehicle moving when the accident occurred? Yes _____ No _____ How fast? _____ MPH
Did another vehicle/s hit your vehicle? Yes _____ No _____ How fast were they going? _____ MPH
Were you struck from: Behind _____ Right Side _____ Left Side _____ Front _____ Other:_____?
Did your vehicle hit other vehicle/s? Yes _____ No _____ Where?_____
Was a police report filed? Yes ____ No ____ Were traffic citations issued? Yes ____ No ____ To Whom?_____
Did Emergency Personnel come? Yes _____ No _____ Did your air bags deploy? Yes _____ No _____
Did you require post-accident hospitalization? Yes _____ No _____ Where?_____
What were the road and weather conditions? _____

SYMPTOMS AFTER ACCIDENT: (Check all that apply) **(Include further details of your symptons on the reverse side)**

□ Headache / Base Of Skull Pain	□ Hip Pain	□ Anxiety
□ Head Seems Too Heavy	□ Pins/Needles In Legs	□ Fatigue
□ Head/Shoulders Tired & Heavy	□ Numbness_____	□ Insomnia
□ Mental Dullness	□ Chest Pain	□ Face Flushed
□ Loss Of Memory	□ Shortness Of Breath	□ Feet Cold
□ Equilibrium Problems	□ Eye Strain	□ Hands Cold
□ Dizziness	□ Pain Behind Eyes	□ Excess Perspiration
□ Fainting	□ Eyes Sensitive To Light	□ Digestive Disorders
□ Tremors	□ Face Pain	□ Nausea
□ Neck Pain	□ Loss Of Smell	□ Vomiting
□ Neck Stiffness	□ Ears Buzzing/Ringing	□ Diarrhea
□ Neck Motion Restricted	□ Double Vision	□ Swollen_____
□ Back Pain	□ Loss Of Taste	□ Fever
□ Back Stiffness	□ Sinus Trouble	□ Cold Sweats
□ Back Motion Restricted	□ Nervousness	□ Difficulty Sitting
□ Shoulder Pain	□ Irritability	□ Difficulty Standing
□ Pins/Needles In Arms	□ Tension	□ Other_____

ATTORNEY: Name:_____ Ph#:_____
Street Address:_____
City:_____ State:_____ Zip:_____

DATE:_____ **SIGNATURE:**_____

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ADDITIONAL NOTES:

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Patient Name:_____ Date:_____

Neck & Upper Back Pain Index

In each section below, please circle the ONE NUMBER which most closely describes your problem right now.

Pain Intensity

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain comes and goes and is moderate.
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.

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 I 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.

Sleeping

0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is completely disturbed (5-7 hours sleepless).

Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes extra pain.
2. I can't lift heavy weights unless they're conveniently positioned, (e.g., on a table).
3. I can't lift medium weights unless they're conveniently positioned, (e.g., on a table).
4. I can lift only very light weights
5. I cannot lift or carry anything at all.

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 cannot read as much as I want because of moderate neck pain.
4. I can hardly read at all because of severe neck pain.
5. I cannot read at all because of neck pain.

Driving

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

Concentration

0. I can concentrate fully when I want with no difficulty.
1. I can concentrate fully when I want with slight difficulty.
2. I have a fair degree of difficulty concentrating when I want.
3. I have a lot of difficulty concentrating when I want.
4. I have a great deal of difficulty concentrating when I want.
5. I cannot concentrate at all.

Recreation

0. I am able to engage in all my recreation activities without neck pain.
1. I am able to engage in all my usual recreation activities with some neck pain.
2. I am able to engage in most of my usual recreation activities with moderate neck pain.
3. I am only able to engage in a few of my usual recreation activities due to neck pain.
4. I can hardly do any recreation activities because of neck pain.
5. I cannot do any recreation activities at all.

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 only do most of my usual work but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

Headaches

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

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100 NECK PAIN INDEX SCORE:_____

0%-20% = Slight Disability, 21%-40% = Mild Disability, 41%-60% = Moderate Disability, 61%-80% = Severe Disability, 81%-100% = Complete Disability

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Mid & Low Back Pain Index

In each section below, please circle the ONE NUMBER which most closely describes your problem right now.

Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Personal Care

0. I do not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it hurts.
2. Washing and dressing increases the pain but I manage not to change how I do it.
3. Washing and dressing increases the pain and I find it necessary to change how I do it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Sleeping

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal sleep is reduced by less than 25%.
3. Because of pain my normal sleep is reduced by less than 50%.
4. Because of pain my normal sleep is reduced by less than 75%.
5. Pain prevents me from sleeping at all.

Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes extra pain.
2. I can't lift heavy weights unless they're conveniently positioned, (e.g., on a table).
3. I can't lift medium weights unless they're conveniently positioned, (e.g., on a table).
4. I can lift only very light weights
5. I cannot lift or carry anything at all.

Sitting

0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than an hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Traveling

0. I get no pain while traveling.
1. I get some pain while traveling but my usual forms of travel do not make it worse.
2. I get extra pain while traveling but it doesn't cause me to seek alternate forms of travel.
3. I get extra pain while traveling which causes me to seek alternate forms of travel.
4. Pain restricts all forms of travel except if it is done while lying down.
5. Pain restricts all forms of travel.

Standing

0. I can stand as long as I want without pain.
1. I have some pain while standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases pain immediately.

Social life

0. My social life is normal and gives me no extra pain.
1. My social life is normal but increases the degree of pain.
2. Pain slightly affects my social life by limiting my energetic interests like dancing.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Walking

0. I have no pain while walking
1. I have mild pain while walking.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Changing degree of pain

0. My pain is rapidly getting better.
1. My pain fluctuates but overall is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better nor worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100 BACK PAIN INDEX SCORE:_____

0%-20% = Slight Disability, 21%-40% = Mild Disability, 41%-60% = Moderate Disability, 61%-80% = Severe Disability, 81%-100% = Complete Disability