Pulliam Chiropractic Clinic, LLC
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AUTOMOBILE ACCIDENT PRELIMINARY INFORMATION

PATIENT INFORMATION: Minor Single Married Divorced Widowed Sex: M F

Last Name:_____First:_____M.I._____

Social Security #_____/_____/_____Date of Birth:_____/_____/_____Age:_____

Address:_____City:_____State:_____Zip:_____

Home#_____ Cell#_____

Place of Employment:_____Phone#_____

Employer's Address:_____

GENERAL INFORMATION

Incase of Emergency Notify:_____Phone:_____Relationship:_____

What other health care have you received for this problem?_____

Is this injury due to an accident: Yes No, Auto Work Other

Date Accident or Illness begin:_____,City and State accident happened in:_____

Who referred you to our office?(Doctor/Friend/Phonebook)_____Phone:_____

Patient(or Parent/Guardian)_____,Today's Date_____

*Signiture:*_____

DO YOU HAVE, OR HAVE EVER HAD, PROBLEMS WITH THE FOLLOWING?

PLEASE CIRCLE

HEADACHES	YES	NO	NOW	PREVIOUS
DIZZINESS	YES	NO	NOW	PREVIOUS
BLURRED VISION	YES	NO	NOW	PREVIOUS
DEPRESSION	YES	NO	NOW	PREVIOUS
NERVOUSNESS	YES	NO	NOW	PREVIOUS
DIFFICULT SLEEP	YES	NO	NOW	PREVIOUS
LOSS OF ENERGY	YES	NO	NOW	PREVIOUS
TIRED IN THE MORNING	YES	NO	NOW	PREVIOUS
BUZZ/RINGING IN EARS	YES	NO	NOW	PREVIOUS
RUN DOWN	YES	NO	NOW	PREVIOUS
FAINTING	YES	NO	NOW	PREVIOUS
PALPITATION	YES	NO	NOW	PREVIOUS

GENERAL PROBLEMS WITH THE FOLLOWING:

HEAD	YES	NO	NOW	PREVIOUS
SINUSES	YES	NO	NOW	PREVIOUS
NECK PAIN/STIFFNESS	YES	NO	NOW	PREVIOUS
SHOULDER PAIN	YES	NO	NOW	PREVIOUS
UPPER BACK	YES	NO	NOW	PREVIOUS
MID BACK	YES	NO	NOW	PREVIOUS
CHEST PAIN	YES	NO	NOW	PREVIOUS
LUNG	YES	NO	NOW	PREVIOUS
HEART	YES	NO	NOW	PREVIOUS
BLOOD PRESSURE	YES	NO	NOW	PREVIOUS
STOMACH	YES	NO	NOW	PREVIOUS
INDIGESTION	YES	NO	NOW	PREVIOUS
BLADDER	YES	NO	NOW	PREVIOUS
KIDNEY	YES	NO	NOW	PREVIOUS
LIVER	YES	NO	NOW	PREVIOUS
COLON	YES	NO	NOW	PREVIOUS
CONSTIPATION	YES	NO	NOW	PREVIOUS
LOW BACK	YES	NO	NOW	PREVIOUS
HIP	YES	NO	NOW	PREVIOUS
LEG PAIN/CRAMPS	YES	NO	NOW	PREVIOUS
POOR CIRCULATION	YES	NO	NOW	PREVIOUS
HIV POSITIVE	YES	NO		

ANY PREVIOUS INJURIES

HOSPITAL/SURGERY YES NO BREAST IMPLANTS YES NO

DESCRIBE CIRCUMSTANCES _____

ARE YOU PREGNANT? _____ NUMBER & AGES OF CHILDREN: _____

ACCIDENTS (FALLS, AUTO, JOB) YES NO

DESCRIBE CIRCUMSTANCES _____

PLEASE LIST ALL MEDICATION YOU ARE TAKING _____

_____

ANY BLOOD RELATIVES WITH BACK PROBLEMS YES NO WHO _____

PATIENT'S SIGNATURE: _____ TODAY'S DATE: _____

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AUTOMOBILE ACCIDENT QUESTIONNAIRE

NAME:_____TODAY'S DATE:_____
DRIVER OF VEHICLE IN WHICH YOU WERE INJURED:
NAME: _____, INSURANCE CO:_____
POLICY NO:_____, CLAIM ADJUSTER: _____
HAVE YOU RETAINED AN ATTORNEY? _____YES, _____NO
IF SO, ATTORNEY NAME & ADDRESS_____
DRIVER OF OTHER VEHICLE:
NAME: _____, INSURANCE CO:_____
POLICY NO: _____, CLIAM/ADJUSTER:_____
PLEASE EXPLAIN IN DETAIL HOW YOUR ACCIDENT HAPPENED: _____

_____

_____

YOU WERE HEADING _____ON _____
(Direction N,S,E,W) (Street/Hwy) (City. State)
OTHER VEHICLE HEADING _____ ON _____
(Direction N,S,E,W) (Street/Hwy) City, State)
WERE POLICE NOTIFIED? _____YES _____NO
WERE YOU KNOCKED UNCONSCIOUS? ____YES ____NO, IF SO HOW LONG?_____
YOU WERE STRUCK FROM ____BEHIND ____FRONT ____LEFT SIDE ____RIGHT SIDE
YOU WERE THE____DRIVER ____PASSENGER ____FRONT SEAT ____BACK SEAT ____SEAT BELT
WHAT WERE THE TIME AND DATE OF PRESENT INJURY?_____
WHERE DID YOU FEEL PAIN IMMEDIATELY AFTER THE ACCIDENT?_____

_____

WHERE WERE YOU TAKEN AFTER THE ACCIDENT?_____
WHAT TREATMENT WAS GIVEN?_____
WAS ANY OTHER DOCTOR CONSULTED AFTER YOUR ACCIDENT? _____YES _____NO
IF SO, WHAT WAS THE DOCTOR'S NAME? _____
WHAT WAS THE DIAGNOSIS?_____ WHAT TREATMENT WAS GIVEN_____
HOW OFTEN AND HOW LONG DID YOU SEE THE DOCTOR? _____
HAVE YOU EVER HAD ANY COMPLAINTS IN THE INVOLVED ARES BEFORE? ____YES ____NO
IF SO, WHAT WERE THE COMPLAINTS? _____
BEFORE THE INJURY WERE YOU CAPABLE OF WORKING ON AN EQUAL BASIS WITH OTHERS YOUR AGE? _____YES _____NO
ARE YOUR WORK ACTIVTIES RESTRICTED SINCE ACCIDENT? _____YES _____NO
SINCE THE INJURY ARE YOUR SYMTOMS ____IMPROVING ____GETTING WORSE ____SAME

_____

SIGNATURE OF PATIENT DATE

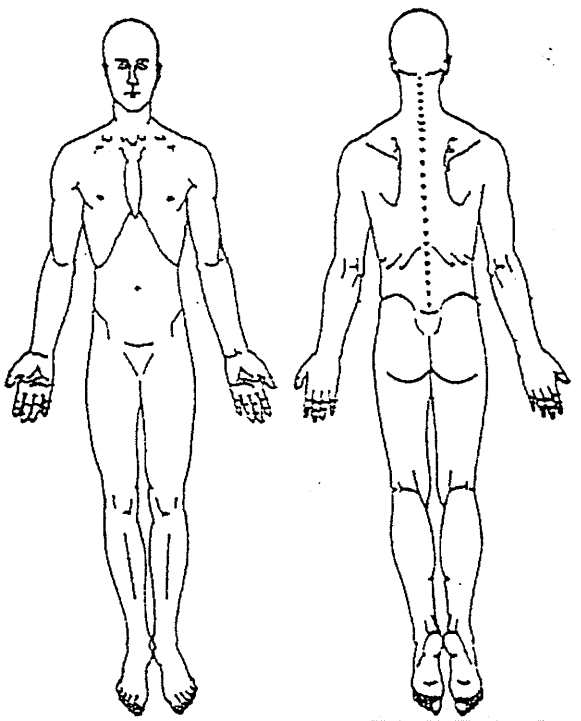
Pain Diagram and Pain Rating

Name _____, **Date:** _____

INSTRUCTIONS: Please use the diagram below to indicate the symptoms you have experienced.. Use the key to indicate the type of symptoms.

KEY:

Pins and Needles = 000000 **Stabbing = / / / / / /** **Numbness = ===**
Burning = xxxxxx **Aching = zzzzzz**



Please rate your current level of pain on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/101

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

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.

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).

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.

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.

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.

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.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

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.

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 but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities 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 Index Score _____

Back Index

ACN Group. Inc. Form BI-100

ACN Group. Inc Use Only rev 12/7/2007

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

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 very severe.
⑤ The pain is very severe and does not vary much.

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.

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 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

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 1/2 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.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

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 causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing 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.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not 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 that done while lying down.
⑤ Pain restricts all forms of travel.

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 has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
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.

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 or 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 Index Score _____