

Name: _____ DOB: _____ Date: _____

Personal Injury Patient Case History

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU!

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____ Occupation _____

Social Security Number _____ Sex M F

Marital Status M S D W Spouse's Name _____

Children's Names & Ages _____

Who referred you to us? _____

How else did you hear about us? _____

ACCIDENT DETAILS

1. Date of accident _____ Time _____ AM/PM Driver of vehicle _____

2. Where were you seated? Driver's seat Front right passenger Front center passenger
 Rear left passenger Rear right passenger Rear center passenger

3. Who owns the car? _____

4. Description of other vehicle involved in accident _____

5. What was the damage done to the car you were in? Mild Moderate Severe Total Unknown

6. Visibility at the time of the accident was: Poor Fair Good

7. The road conditions at the time of the accident were: Snow/Icy Wet Clear Dark

8. Type of accident: Was hit in the... Rear Right side Left side Front
 Hit another car in the... Rear Right side Left side Front

9. If this was not a collision, please describe: _____

10. Were you aware the accident was about to happen? Yes No

11. Did you brace for the impact? Yes No

12. Were you wearing a seat belt? Yes No Shoulder harness? Yes No

13. Did the car you were in have a headrest? Yes No

If yes, what was the position of the headrest compared to your head *before* the accident?

Top of headrest even with bottom of the head

Top of headrest even with top of head

Top of headrest even with middle of neck

14. Was the car equipped with an airbag where you were seated? Yes No

If yes, did the airbag inflate? Yes No

Were you injured by the inflating airbag? Yes No

If yes, what were your injuries? _____

15. Was your car braking? Yes No

16. Was your car moving at the time of the accident? Yes No

If yes, how fast would you estimate you were going? _____ MPH (estimate)

17. How fast would you estimate the other car was going? _____ MPH (estimate) Don't know

18. Describe in your own words what happened to you upon impact: _____

19. Head and body position at the time of impact was:

Head turned... Right Left Head straight forward Head looking back

Body rotated... Right Left Body straight in sitting position

20. At the time of the accident, what parts of your head or body hit what parts on the inside of your car?

21. As a result of the accident, you were: Rendered unconscious Dazed, circumstances vague

Shaken up but could think clearly and function

22. Could you move all parts of your body? Yes No

If no, what body parts could you not move, and why not? _____

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23. Were you able to get out of the car and walk unaided? Yes No
If no, why not? _____
24. Did you receive any medical assistance at the scene of the accident? Yes No

Illustrate below how the accident happened:

SYMPTOMS FROM ACCIDENT

1. Did you get any bleeding cuts? Yes No If yes, where? _____
2. Did you get any bruises? Yes No If yes, where? _____
3. Please describe how you felt:
 - Immediately after the accident _____
 - Later that day _____
 - The next days _____
4. Check symptoms apparent **since** the accident:

<input type="checkbox"/> Headache	<input type="checkbox"/> Neck pain/ stiffness	<input type="checkbox"/> Mid-back pain	<input type="checkbox"/> Low-back pain
<input type="checkbox"/> Eyes light sensitive	<input type="checkbox"/> Pain behind eyes	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting
<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Loss of taste
<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Loss of memory	<input type="checkbox"/> Loss of balance
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Ringing/ buzzing	<input type="checkbox"/> Irritability	<input type="checkbox"/> Depression
<input type="checkbox"/> Cold hands	<input type="checkbox"/> Cold feet	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation
<input type="checkbox"/> Tension	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Cold sweats
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Facial pain	<input type="checkbox"/> Clicking or popping jaw	
<input type="checkbox"/> Other _____			
5. Describe your primary complaints, name the body parts: _____

- a. How often does it affect you? constant intermittent
- b. Symptom severity is currently: mild moderate severe
- c. Symptom is currently: increasing decreasing not changing
- d. Symptom is worse in the: morning afternoon night same all day
- e. If there is pain, is it: sharp dull ache shooting tingling radiating stabbing other _____

PAIN LEVEL: On a scale of 0 - 10,
with 0 being pain free and can function quite well,
and 10 being excruciating pain all the time, where
would you rate the intensity of your pain?

0	1	2	3	4	5	6	7	8	9	10
No		Low		Moderate		Intense		Excruciating		
Pain		Pain		Pain		Pain		Pain		

- f. What is your ability to perform the following activities? U=unable, P=painful, L=limited, N=normal
- | | | |
|------------------------------------|-------------------------|-------------------|
| ____ Coughing or sneezing | ____ Climbing | ____ Kneeling |
| ____ Getting in or out of car | ____ Balancing | ____ Looking back |
| ____ Putting on clothes | ____ Putting on shoes | ____ Stooping |
| ____ Turning over in bed | ____ Getting out of bed | ____ Pushing |
| ____ Lying flat on stomach | ____ Gripping | ____ Pulling |
| ____ Lying on side with knees bent | ____ Reaching | |

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- g. What makes the symptom better? nothing sitting lying down walking moving bending/twisting
other _____
- h. What makes the symptom worse? nothing sitting lying down walking moving bending/twisting
other _____

Modified Oswestry Pain Disability Questionnaire

Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that 2 of the statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

Pain Intensity

- The pain comes and goes and is very mild.
 The pain is mild and does not vary much.
 The pain comes and goes and is moderate.
 The pain is moderate and does not vary much.
 The pain is severe but comes and goes.
 The pain is severe and does not vary much.

Walking

- Pain does not prevent me from walking any distance.
 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 with crutches or a cane.
 I am in bed most of the time and have to crawl to the toilet.

Sitting

- I can sit in any chair as long as I like.
 I can only sit in my favorite chair 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.

Sleeping

- Pain does not prevent me from sleeping well.
 I get pain in bed, but it does not prevent me from sleeping.
 Because of pain, my normal night's sleep is reduced by less than one-quarter.
 Because of pain, my normal night's sleep is reduced by less than one-half.
 Because of pain, my normal night's sleep is reduced by less than three-quarters.
 Pain prevents me from sleeping at all.

Personal Care (e.g., Washing, Dressing)

- I can take care of myself normally without causing increased pain.
 I can take care of myself normally, but it increases my pain.
 It is painful to take care of myself, & I am slow & careful.
 I need help, but I am able to manage most of my personal care.
 I need help every day in most aspects of my care.
 I do not get dressed, wash with difficulty, & stay in bed.

Standing

- I can stand as long as I want without increased pain.
 I can stand as long as I want, but it increases my pain.
 Pain prevents me from standing for more than 1 hour.
 Pain prevents me from standing for more than 1/2 hour.
 Pain prevents me from standing for more than 10 min.
 Pain prevents me from standing at all.

Lifting

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

Social Life

- My social life is normal and does not increase my pain.
 My social life is normal, but it increases my level of pain.
 Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
 Pain prevents me from going out very often.
 Pain has restricted my social life to my home.
 I have hardly any social life because of my pain.

Traveling

- I can travel anywhere without increased pain.
 I can travel anywhere, but it increases my pain.
 My pain restricts my travel over 2 hours.
 My pain restricts my travel over 1 hour.
 My pain restricts my travel to short necessary journeys under 1/2 hour.
 My pain prevents all travel except for visits to the doctor/chiropractor or hospital.

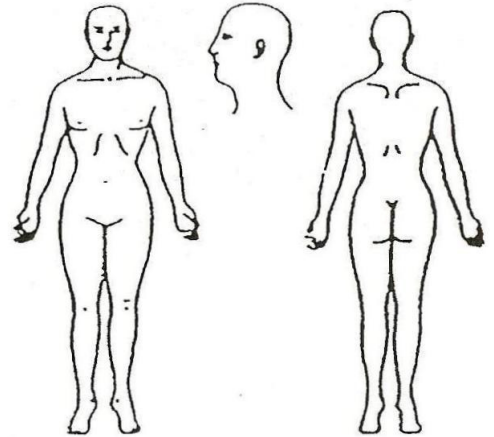
Employment / Homemaking

- My normal homemaking / job activities do not cause pain.
 My normal homemaking / job activities increase my pain, but I can still perform all that is required of me.
 I can perform most of my homemaking / job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
 Pain prevents me from doing anything but light duties.
 Pain prevents me from doing even light duties.
 Pain prevents me from performing any job/ homemaking chores.

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MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles Stabbing ////



WORK STATUS HISTORY

Occupation: _____

Employer: _____

Have you missed time from work? Yes No

If yes, were you unable to work since the accident? Yes No

If yes, full time off work from _____ to _____

If yes, part time off work from _____ to _____

INJURY TREATMENT

1. Have you treated your symptoms at home? ice heat medication other _____

2. Did you seek medical help immediately after the accident? Yes No

If yes, what hospital/clinic did you go to? _____

If yes, how did you get there? Ambulance Police Someone else drove me Drove myself
 Other _____

Were you hospitalized as a result of this accident? Yes No

Doctor 1: Name _____ Date of first visit _____

Were you examined? Yes No Were X-rays taken? Yes No

Did you receive treatment? Yes No

If yes, what kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

Date of last treatment _____

Doctor 2: Name _____ Date of first visit _____

Were you examined? Yes No Were X-rays taken? Yes No

Did you receive treatment? Yes No

If yes, what kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

Date of last treatment _____

PRIOR SIMILAR SYMPTOMS

1. Did you have any physical complaints **just before this accident**? Yes No

If yes, please describe any physical complaints **just before this accident**: _____

2. Have you EVER had any PRIOR injuries, accidents, diseases, or treatment to the area of your body now affected? Yes No

If yes, state what part of your body was previously injured and describe the injury: _____

Were you treated? Yes No If yes, who treated you? _____

What date did the treatment begin? _____ When did the treatment end? _____

When was the last time (date) that you felt pain or problems from that injury? _____

Name: _____ DOB: _____ Date: _____

HEALTH HISTORY

1. Have you suffered injuries in the past? yes no
car accident date _____ falls date _____ hospitalization date _____
fracture date _____ sprain/strain date _____ other _____
2. Do you have a family history of:
heart disease cancer arthritis diabetes lung conditions high blood pressure
stroke/vascular problems kidney or liver conditions other _____
3. Do you have a family physician? Name: _____
4. Please list any disease or condition with which you have been diagnosed _____

5. Please list any medications or nutritional supplements that you are currently taking _____

6. Please list any surgical operations and dates _____

Review of Systems

- | Past | Present | | Past | Present | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Neck or back pain | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Constipation/irregular bowel habits |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw pain | <input type="checkbox"/> | <input type="checkbox"/> | Liver or gallbladder problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Arm, shoulder, elbow, wrist or hand pain | <input type="checkbox"/> | <input type="checkbox"/> | Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg, hip, knee, ankle or foot pain | <input type="checkbox"/> | <input type="checkbox"/> | Irritable bowel or colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling or stiffness of joints | <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness, loss of sensation, or tingling | <input type="checkbox"/> | <input type="checkbox"/> | Bloating or gas |
| <input type="checkbox"/> | <input type="checkbox"/> | General fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids |
| <input type="checkbox"/> | <input type="checkbox"/> | Troubled sleep | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of memory | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn or indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Aortic aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual disturbances | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear noises or ringing | <input type="checkbox"/> | <input type="checkbox"/> | Heart palpitations |
| <input type="checkbox"/> | <input type="checkbox"/> | Hard of Hearing | <input type="checkbox"/> | <input type="checkbox"/> | Chest pains or angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Earache | <input type="checkbox"/> | <input type="checkbox"/> | Heart attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear Fluid | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath or wheezing | <input type="checkbox"/> | <input type="checkbox"/> | Asthma or Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough or chronic sinusitis | <input type="checkbox"/> | <input type="checkbox"/> | Skin rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Runny nose or post nasal drip | <input type="checkbox"/> | <input type="checkbox"/> | Cancer or non-cancerous tumor |
| <input type="checkbox"/> | <input type="checkbox"/> | Throat soreness or hoarseness | <input type="checkbox"/> | <input type="checkbox"/> | Blood disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic ear or throat infections | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of taste or appetite | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis (or Rheumatoid arthritis) |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal weight gain or loss | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive thirst | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Heat or cold intolerance | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of bladder control | <input type="checkbox"/> | <input type="checkbox"/> | Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful or frequent urination | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder infection | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disorder or stones | | | |



Name: _____ DOB: _____ Date: _____

Men Only

- Prostate problems
- Erectile dysfunction
- Testicular pain

Women Only (cont.'d)

- Endometriosis
- Recurrent yeast or fungal infection
- Hot flashes

Women Only

- Irregular menstrual flow
- Breast soreness or lumps
- Menstrual cramping
- PMS

Duration of cycle _____ Duration of flow _____
 Menstrual flow: Heavy Moderate Light
 Last period _____
 No. Pregnancies _____ No. Births _____
 Contraception Type _____

Men & Women: Height _____ Weight _____

Please list any other health concerns you have that you would like the doctor to be aware of _____

Thank you!

AUTOMOBILE INSURANCE INFORMATION

Insurance Company Name _____
 Policy # _____
 Accident Claim # _____
 Agent's Name _____ Phone # _____
 Adjuster's Name _____ Phone # _____

LEGAL INFORMATION

Do you have an attorney on this case? Yes No If yes, whom? _____

Note: Patients involved in litigation (lawsuits) or third party payment are ultimately responsible for payment of services.

OFFICE FINANCIAL POLICY

All claims will first be submitted to your insurance company and, following receipt of benefits, a statement of your responsibility will be sent to you. In order to avoid accumulating an unmanageable balance, individual accounts are not allowed to exceed \$200 and family accounts cannot surpass \$300. Chiropractic care will not be rendered if balances exceed these amounts. We welcome periodic payments while we wait to hear back from your insurance company in order to keep your account balance manageable.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

Your signature on this intake form denotes that you understand the above policies and agree to abide by the same. You understand that you are ultimately responsible for all charges whether or not covered by the automobile insurance claim. For your convenience, we accept cash, check, Visa and MasterCard. Your signature below authorizes the doctor(s) to release all information necessary to secure the payment of benefits from your automobile insurance carrier. In addition, your signature authorizes the use of your signature here on all claim submissions.

Patient's signature: _____ **Date:** _____

Parent/ Guardian or other signature: _____

Cornerstone Chiropractic Staff: _____