

INJURY HISTORY FORM

Patient Name: _____ **Date:** _____

Date of injury: _____ **Time of injury:** _____ AM/PM

Crash occurred: _____
(Street) (City) (State)

Owner of the vehicle you were in: _____

Describe how the crash happened: _____

Street was: Wet Dry **Weather was:** Clear Cloudy Rainy Snowy **Visibility was:** Good Poor

Collision Description/Type: _____

Number of cars involved: Single Two Multiple

Point(s) of impact: Rear-end Front-end Driver Side Passenger Side Rollover
Hit object _____ Ran off the road Other _____

Did the police come to the scene? Yes No **Did they write a report?** Yes No

Were photographs taken? Yes No **If yes, who took them?** _____

Estimated damages to your vehicle: \$ _____ **Who made the estimate?** _____

Describe damages to your vehicle: _____

Describe the vehicle you were in: Automatic Manual Unknown

Make: _____ **Model:** _____ **Year:** _____

Size: Small Mid-sized Large **Number of Doors:** 2-door 4-door

Type: Truck Sedan Van SUV Bus Semi truck Hatchback Station-wagon

Where were you sitting? Driver Front passenger Right rear Left rear

Describe the other vehicle: Automatic Manual Unknown

Make: _____ **Model:** _____ **Year:** _____

Size: Small Mid-sized Large **Number of Doors:** 2-door 4-door

Type: Truck Van SUV Bus Semi truck Sedan Hatchback Station-wagon

Patient Name: _____

Estimated crash speeds: Your vehicle: _____ Other Vehicle: _____

At the time of impact your vehicle was: Slowing down Moving at a steady speed
Gaining speed Stopped without brake Stopped with brake engaged

At time of impact the other vehicle was: Slowing down Moving at a steady speed
Gaining speed Stopped Unknown

Indicate if your body hit anything in the vehicle:

Body region: _____ Object hit: _____
Body region: _____ Object hit: _____

Was there any bruising following the crash? Yes No **If yes, where?** _____

Where any of the following vehicle parts broke, bent, or damaged in your car:

Windshield	Steering Wheel	Dash	Seat frame	Mirror
Side/rear window	Knee bolster	Brake pedal	Other	None

Awareness and Body Position Descriptions: _____

Seatbelt Harness:

Were you wearing a seatbelt? Yes No

Was any portion of your seatbelt positioned behind your back or neck? Yes No

Steering Wheel Hand Position:

Were you holding onto the steering wheel at the time of impact? Yes No

If yes, please describe position using time clock face as reference point: R ____ L ____

Were you reaching for something at time of impact? Yes No

If yes, were you reaching: Forward or Behind the seat **Which Arm?** Right Left

Airbag Deployment:

Did the airbags deploy? Yes No **If yes, which airbags?** Front driver Front passenger Side

Patient Name: _____

Awareness:

Were you aware of the pending impact? Yes No

At the time of impact were you:

Braced for impact Leaning forward Relaxed Pressed into the seat Reclined backwards

What was your head position at the time of impact?

Facing forward Turned right Turned left

Was your torso turned at time of impact? Yes No **If yes, which direction?** Right Left

Rear-end Collisions Only:

Describe your vehicle's head restraint system:

Fixed Moveable/adjustable Bench seat None

Describe the position of your head restraint at the time of impact:

Top of head Mid head Low head/base of neck Base of neck/upper back

Estimated distance between back of head and the headrest: _____

Did your head hit the head restraint? Yes No

Did your headrest change position after the crash? Yes No

Did the seatback change position after the crash? Yes No

Post-Traumatic Symptoms Following the Crash:

Since the crash, have you experienced (please circle):

Loss of consciousness	Sore throat	Headaches
Trouble sleeping	Dizziness	Trouble concentrating
Fatigue	Ringing in the Ears	Irritability
Memory problems	Blurred vision	Ache/pain in jaw
Emotional outbursts	Neck pain	Pain w/swallowing
Anxiety	Shoulder pain	Low back pain
Nausea	Arm pain	Leg pain

Patient Name: _____

Which daily activities have your injuries interfered with and how much?

Immediate Symptoms:

Current Symptoms:

What makes your symptoms worse?

What makes your symptoms better?

Prior Treatments for these Injuries: none

Type: _____

Area: _____

Duration: _____

Facility: _____

Imaging: _____

Prior Symptoms: none

Area: _____

Intensity: _____

Duration: _____

Area: _____

Intensity: _____

Duration: _____

NECK PAIN AND DISABILITY INDEX

Patient Name: _____ Date: _____

Please read instructions carefully: This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section then mark the box that most closely describes your problem.

SECTION 1 – PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is worse than imaginable at the moment.

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 everyday 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 objects without any extra pain.
- I can lift heavy objects, but it gives extra pain.
- Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- I can only lift very light objects.
- I cannot lift or carry anything at all.

SECTION 4 – READING

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with light pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I can't read as much as I want to because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

SECTION 5 – HEADACHES

- I have no headache at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7 – WORK

- I can do as much work as I want.
- I can do only my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly work at all.
- I cannot do any work at all.

SECTION 8 – DRIVING

- I can drive without any neck pain.
- I can drive as long as I want with slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I cannot drive at all.

SECTION 9 - SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr sleepless).
- My sleep is mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 – RECREATION

- I am able to engage in all my recreational activities with no neck pain.
- I am able to engage in all my recreational activities with some neck pain.
- I am able to engage in most, but not all of my usual recreational activities because of neck pain.
- I am able to engage in a few of my usual recreational activities because of neck pain.
- I can hardly do any recreational activities because of neck pain.
- I cannot do any recreational activities at all.

NECK PAIN SCALE

Rate the severity of your Neck Pain by indicating on the following scale.

Absent I-----I Extreme

LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: _____ Date: _____

Please read instructions carefully: This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section then mark the box that most closely describes your problem.

SECTION 1 – 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 comes and goes and is very severe.
- The pain is severe and does not vary much.

SECTION 2 – PERSONAL CARE

- I do not have to change my way of washing or dressing to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – LIFTING

- I can lift heavy objects without any extra pain.
- I can lift heavy objects, but it gives extra pain.
- Pain prevents me from lifting heavy objects off the floor.
- Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- I can only lift very light objects at the most.

SECTION 4 – WALKING

- I have no pain on walking.
- I have some pain but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1 / 2 mile without increasing pain.
- I cannot walk more than 1 / 4 mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5 – 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 more than one hour.
- Pain prevents me from sitting more than half an hour.
- Pain prevents me from sitting more than ten minutes.
- I avoid sitting because it increases pain.

SECTION 6 - STANDING

- I can stand as long as I want without pain.
- I have some pain on standing but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand longer than ten minutes without increasing pain.
- I avoid standing because it increases the pain.

SECTION 7 – SLEEPING

- I have no pain in bed.
- I have pain in bed but it does not prevent me from sleeping well.
- Pain reduces my normal sleep by 1 / 4 each night.
- Pain reduces my normal sleep by 1 / 2 each night.
- Pain reduces my normal sleep by 3 / 4 each night.
- Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- My social life is unaffected by pain apart from limiting more energetic interests.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

SECTION 9 – DRIVING / RIDING IN CAR

- I have no pain while traveling.
- I have some pain while traveling but none of my usual forms of travel make it any worse.
- I have extra pain while traveling but it does not compel me to seek alternate forms of travel.
- I have extra pain while traveling which compels me to seek alternate forms of travel.
- Pain restricts all forms of travel.
- Pain restricts all forms of travel except those done lying down.

SECTION 10 – CHANGING DEGREE OF PAIN

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at present.
- My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

LOW BACK PAIN SCALE

Rate the severity of your **Low Back Pain** by indicating on the following scale.

Absent I-----I Extreme

INJURY CLAIM INFORMATION

Name: _____ **Date of Injury:** _____

Your Insurance Information

Name of Policy Holder: _____

Insurance Company: _____

Insurance Company's Phone #: _____

Claim Adjuster/Agent's Name: _____

Policy Number: _____

Claim Number: _____

Attorney's Name: _____

Attorney's Address: _____

Attorney's Phone Number: _____

Attorney's Fax Number: _____

Legal Assistant/Paralegal's Name: _____

Release of Information and Assignment of Benefits

I authorize Gretchen Blyss, DC to release my records in order to obtain payment on my account for services provided to me. I authorize payment for such services to be paid directly to Gretchen Blyss, DC. I understand that I am financially responsible for any charges not paid by my insurance carrier or attorney.

Signature: _____ **Date:** _____