MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

PATIENT INFORMATION

Name: _____ *DOB*: _____ *Today's date*: _____

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

What are your present complaints / symptoms as a result of the accident? _____

_____

_____

Please check symptoms you have noticed since the accident:

___ neck pain	___ loss of balance	___ upper back pain	___ cold sweats
___ stiffness in neck	___ loss of memory	___ lower back pain	___ nervousness / anxiety
___ headache	___ face flushed	___ pins & needles in legs	___ irritability
___ dizziness	___ pins & needles in arms	___ numbness in legs / feet	___ fatigue
___ sensitivity to light	___ numbness in hand / arm	___ pain into legs / feet	___ fainting
___ head feels "heavy"	___ pain into arms / hand	___ cold feet	___ depression
___ loss of smell	___ cold hands	___ constipation / diarrhea	___ sleep problems
___ loss of taste	___ tension	___ chest pain	___ fever
___ buzzing in ears	___ ringing in ears	___ shortness of breath	___ upset stomach

Did you have any physical complaints before this accident? Yes No

Please describe: _____

_____

Occupation: _____

Have you missed time from work? Yes No *If yes, dates missed*: From _____ To _____

ACCIDENT DETAILS

Driver of car you were in? _____ *Owner of car?* _____

Where in car were you seated?

Front – Driver's Side Front – Passenger Side

Rear – Driver's Side Rear - Middle Rear – Passenger Side

In your own words, please describe the accident: _____

_____

_____

_____

Where was your car struck?

Head-On Collision	Rear Impact	Non-Collision
Broad-Side Collision on Right	Broad-Side Collision on Left	Other: _____

Please explain damage done to the car you were in: _____

_____

Visibility at time of accident: Poor Fair Good Other: _____

Road conditions at time of accident: Icy Rainy Wet Clear Dark Other: _____

What was your head / body position at the time of impact?

Head Straight Forward	Head Turned Left / Right	Head Looking Back
Body Straight in Sitting Position	Body Turned Left / Right	Other: _____

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

_____

_____

Did you see the accident coming?	Yes	No	Not Sure
Did you brace for impact?	Yes	No	Not Sure
Were you wearing a seatbelt?	Yes	No	Not Sure
Does the car have headrests?	Yes	No	Not Sure
Was your car braking?	Yes	No	Not Sure
Was your car moving at the time of the accident?	Yes	No	Not Sure

If yes, how fast was your car moving? _____

How fast would you estimate the other vehicle was moving? _____

Please describe how you felt:

- *During the accident –* _____
- *Immediately after the accident –* _____
- *Later that day –* _____
- *The next day –* _____

Were you given medical attention after the accident? Yes No

If yes, how did you get there? Ambulance Police Drove Own Car Someone Else Drove Me

Other: _____

Name of medical facility: _____ *Date of medical examination:* _____

Name of doctor seen: _____ *Was imaging / testing performed?* Yes No

If yes, what kind? X-ray CT MRI Blood Test

Other: _____

Did you receive any form of treatment? Yes No

If yes, what kind? Medication Brace Collar Other: _____

If yes, did the treatment benefit you? Yes No

How so? _____

Have you seen anyone else for this condition? Yes No

Name of person(s) seen: _____

Do you have an attorney in regards to this claim? Yes No

Attorney's name: _____ *Law firm:* _____

Address: _____ *Phone:* _____

ACTIVITIES OF DAILY LIVING ASSESSMENT

DIRECTIONS: Please check the ***ONE*** item in each section which most closely applies to you.

PAIN INTENSITY

___ I can tolerate the pain I have without painkillers.
___ The pain is bad, but I manage without painkillers.
___ Painkillers give complete relief from pain.
___ Painkillers give moderate relief from pain.
___ Paikillers give very little relief from pain.
___ Painkillers give no relief from pain and I do not use them.

PERSONAL CARE

___ I can look after myself normally without causing extra pain.
___ I can look after myself normally, but it results in extra pain.
___ It is painful to look after myself so I am slow and careful.
___ I need some help everyday in most aspects of self-care.
___ I do not get dressed, I wash with difficulty, and I stay in bed.

LIFTING

___ I can lift heavy weights without extra pain.
___ I can lift heavy weights, but it causes extra pain.
___ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. 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 only lift light weights.
___ I cannot lift or carry anything at all.

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 ½ mile.
___ Pain prevents me from walking more than ¼ mile.
___ I can only walk using a cane or a crutch.
___ I am in bed most of the time and must 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 for as long as I like.
___ Pain prevents me from sitting for more than 1 hour.
___ Pain prevents me from sitting for more than 30 minutes.
___ Pain prevents me from sitting for more than 10 minutes.
___ Pain prevents me from sitting at all.

STANDING

___ I can stand as long as I want without pain.
___ I can stand as long as I want, but it causes extra pain.
___ Pain prevents me from standing more than 1 hour.
___ Pain prevents me from standing for more than 30 minutes.
___ Pain prevents me from standing for more than 10 minutes.
___ Pain prevents me from standing at all.

SLEEPING

___ Pain does not prevent me from sleeping well.
___ I can sleep well only by using medication / pills.
___ Even when I take meds I will sleep less than 6 hours.
___ Even when I take meds I will sleep less than 4 hours.
___ Even when I take meds I will sleep less than 2 hours.
___ Pain prevents me from sleeping at all.

SEX LIFE

___ My sex life is normal and causes no extra pain.
___ My sex life is normal, but causes extra pain.
___ My sex life if nearly normal, but is very painful.
___ My sex life is severely restricted by pain.
___ My sex life is nearly absent because of pain.
___ Pain prevents any sex life at all.

SOCIAL LIFE

___ My social life is normal and without extra pain.
___ My social life is normal, but results in extra pain.
___ Pain has no significant effect on my social life apart from limiting my more energetic interests (i.e. dancing, etc.)
___ Pain has restricted my social life and I do not go out as often as I would like.
___ Pain has restricted my social life to my home.
___ I have no social life because of pain.

TRAVELING

___ I can travel anywhere without extra pain.
___ I can travel anywhere, but it causes extra pain.
___ Pain is bad, but I can manage journeys over 2 hours.
___ Pain restricts me to journeys less than 1 hour.
___ Pain restricts me to short necessary trips under ½ hour.
___ Pain restricts me from all travel, except to the doctor or hospital.

Concord Chiropractic
Dr. James A. Ferraro D.C
(302) 368-3300

INFORMED CONSENT

I have received information about my condition and proposed chiropractic treatment program as well as alternative courses of care, the benefits, the risks, and the side effects of the treatment and the consequences of not having the proposed treatment.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some rare risks to treatment, including but not limited to, muscle strain and sprain, fracture, dislocation, disc injuries, temporary exacerbation of symptoms, and altered blood flow to the head and brain.

My doctor has responded to all my requests for information about the proposed treatment. I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content. By signing below, I consent to chiropractic treatment.

Print Patient's Name	Signature of Patient	Date
Print Parent/Guardian Name	Signature of Parent/Guardian	Date
Print Witness Name	Signature of Witness	Date

Concord Chiropractic
Dr. James A. Ferraro D.C
(302) 368-3300

Authorization Form

Patient Name:(print)_____ **SS#:** _____-_____-_____

RELEASE OF INFORMATION

I hereby authorize Concord Chiropractic to release medical and financial data to my insurance carriers, other medical facilities, and attorney(s).

Initials: _____

RESPONSIBILITY OF BILL

The undersigned hereby accepts full financial responsibility for charges and services rendered. The undersigned understands that services are rendered and charged to you (the patient) and not your insurance company. Concord Chiropractic does not accept total responsibility for collecting an insurance claim or negotiating a disputed settlement. It is the financial obligation of the undersigned to be responsible for any charges or services not covered by insurance for which payment is denied through any utilization review or pre-certification procedures, or any remaining balance upon completion of settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement.

Initials: _____

CONSENT FOR TREATMENT OF A MINOR CHILD

Consent is hereby given by the undersigned for Chiropractic treatment, X-Rays, Acupuncture, any diagnostic studies as ordered by the doctors, and therapies (therapeutic massage, electrical stimulation, ice/heat therapy, hydrotherapy, therapeutic exercises) performed by the technical staff of Concord Chiropractic. The undersigned states that he/she is the patient's legal guardian.

Initials: _____

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby irrevocably authorize payments of my medical benefits otherwise payable to me to be made payable and mailed directly to Concord Chiropractic for professional services rendered. No other third party, including my attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledged medical coverage and will send payments directly to this office.

Initials: _____

X_____ _____ ____/____/____

Patient or Guardian Signature **Relationship to Patient** **Date**