Auto Accident Forms

Patient Name__________________________ **Date**_____________

Please mark your involvement in the Auto Accident: ☐Pedestrian ☐Driver ☐Passenger

What are your current symptoms? ☐Pain ☐Numbness ☐Stiffness ☐Weakness

Date of Accident___________

Patient was located: ☐Driver ☐Passenger-middle front ☐Passenger-right front
☐ Passenger-left rear ☐Passenger- middle rear ☐Passenger –right rear

Patient Vehicle Type: ☐Compact ☐ Mid-Size ☐ Full-Size ☐ SUV ☐ Pick-Up ☐ Motorcycle

Second Vehicle Type: ☐Compact ☐ Mid-Size ☐ Full-Size ☐ SUV ☐ Pick-Up ☐ Motorcycle

Third Vehicle Type: ☐Compact ☐ Mid-Size ☐ Full-Size ☐ SUV ☐ Pick-Up ☐ Motorcycle

Road Conditions: ☐ Clear ☐Dark ☐Dry ☐Wet ☐Icy ☐Foggy

Road Type: ☐ Asphalt ☐ Concrete ☐ Dirt ☐ Gravel

Were you aware the accident was going to occur? ☐Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐No

Did your airbag deploy? ☐ Yes ☐No

What position was the head rest in? ☐ Up ☐Middle ☐Down

Patient's Head Position: ☐Looking Straight Ahead ☐Left Level ☐Left Up ☐Left Down
☐Right Level ☐Right Up ☐Right Down ☐Looking Down ☐Looking Up

Accident Details

Was your car breaking? ☐ Yes ☐No **Was your car moving?** ☐ Yes ☐No
If yes, how fast?(mph) ☐ <5 ☐6-10 ☐11-15 ☐16-20 ☐21-30 ☐31-40 ☐41-50 ☐51-60 ☐61-70 ☐>70

Was the second vehicle breaking? ☐ Yes ☐No **Was the second vehicle moving?** ☐ Yes ☐No
If yes, how fast? (mph) ☐ <5 ☐6-10 ☐11-15 ☐16-20 ☐21-30 ☐31-40 ☐41-50 ☐51-60 ☐61-70 ☐>70

Was the third vehicle breaking? ☐ Yes ☐No **Was the third vehicle moving?** ☐ Yes ☐No
If yes, how fast? (mph) ☐ <5 ☐6-10 ☐11-15 ☐16-20 ☐21-30 ☐31-40 ☐41-50 ☐51-60 ☐61-70 ☐>7

Collision Details

First Impact: ☐Hit by other vehicle ☐Hit other vehicle ☐Hit by object ☐Hit object
Impact Location: ☐Front ☐Front-right ☐Front-left ☐ Left ☐ Right ☐Right-rear
☐Top ☐Rear ☐Left-rear

Second Impact: ☐Hit by other vehicle ☐Hit other vehicle ☐Hit by object ☐Hit object
Impact Location: ☐Front ☐Front-right ☐Front-left ☐ Left ☐ Right ☐Right-rear
☐Top ☐Rear ☐Left-rear

Collision Results

The NDI is scored the same way as the Oswestry Disability Index
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Body was thrown: ☐Forward ☐Backward ☐Left ☐Right ☐Can't Remember

Head Hit: ☐Airbag ☐Front Windshield ☐Rearview Mirror ☐Steering Wheel ☐Back of the front seat ☐Side window/ door ☐Another person's body ☐Headrest

Chest Hit: ☐Airbag ☐Back of the front seat ☐Side window/ door ☐Dashboard ☐Another person's body ☐Steering Wheel

Shoulders Hit: ☐Shoulder harness ☐Side window/door ☐Back of front seat ☐Another person's body

Knees Hit: ☐Steering wheel ☐Dashboard ☐Back of front seat ☐Door panel ☐Center console ☐Another person's body

Hips Hit: ☐Steering wheel ☐Dashboard ☐ Back of front seat ☐Door panel ☐Center console ☐Another person's body

Vehicle Damage

Patient Vehicle: ☐Totaled ☐Significant Damage ☐Light Damage ☐No Damage
Second Vehicle: ☐Totaled ☐Significant Damage ☐Light Damage ☐No Damage
Third Vehicle: ☐Totaled ☐Significant Damage ☐Light Damage ☐No Damage

Hospitalized

Were you hospitalized? ☐No ☐Yes If yes, please answer the questions below.

When were you hospitalized? ☐Immediately ☐Later same day ☐ Next day ☐Date_______

How were you transported to the hospital? ☐Ambulance ☐Life flight ☐Private transportation

What did the hospital recommend? ☐No instructions ☐See this clinic ☐See DC ☐See own doctor ☐See orthopedist ☐See neurologist ☐Prescription medication

Did you have any x-rays taken? ☐No ☐Yes
If yes, what areas? ____

Do you have an attorney? ☐No ☐Yes
If so, please give us their contact information.
Name:_______________________ Street:_______________________
City:_______________ State: ________ Zip:________ Phone #:_______________

Do you have major medical insurance coverage on your car? ☐No ☐Yes
Name of insurance company:_______________ Zip________ City______________ State____
Street__________________ ___ Phone Number:_________________________ Adjuster's Name:____________________________ Claim #:_________________________

Does the other party involved have insurance coverage? ☐No ☐Yes Name of insurance company:________________ Zip________ City______________ State____ Street_____________________
Phone Number:_________________________ Adjuster's Name:____________________________ Claim #:_________________________

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Tell Us About You

How were you feeling before the accident?____

____

Please indicate which of the following were noticed after the accident. If they were noticed, were they noticed immediately, within a few hours, the next day, or later? Circle which side **L=Left**, **R=Right**, circle **L & R if both** sides were hurt.

Symptom		Immediate	Few Hours	Next day	Later
☐ Headache		☐	☐	☐	☐
☐ Neck Pain	L / R	☐	☐	☐	☐
☐ Shoulder Pain	L / R	☐	☐	☐	☐
☐ Shoulder Numb	L / R	☐	☐	☐	☐
☐ Upper Arm Pain	L / R	☐	☐	☐	☐
☐ Upper Arm Numb	L / R	☐	☐	☐	☐
☐ Elbow Pain	L / R	☐	☐	☐	☐
☐ Elbow Numb	L / R	☐	☐	☐	☐
☐ Lower Arm Pain	L / R	☐	☐	☐	☐
☐ Lower Arm Numb	L / R	☐	☐	☐	☐
☐ Wrist Pain	L / R	☐	☐	☐	☐
☐ Wrist Numb	L / R	☐	☐	☐	☐
☐ Hand Pain	L / R	☐	☐	☐	☐
☐ Hand Numb	L / R	☐	☐	☐	☐
☐ Upper Back Pain	L / R	☐	☐	☐	☐
☐ Middle Back Pain	L / R	☐	☐	☐	☐
☐ Low Back Pain	L / R	☐	☐	☐	☐
☐ Chest Pain	L / R	☐	☐	☐	☐
☐ Abdomen Pain	L / R	☐	☐	☐	☐
☐ Hip Pain	L / R	☐	☐	☐	☐
☐ Hip Numb	L / R	☐	☐	☐	☐
☐ Upper Leg Pain	L / R	☐	☐	☐	☐
☐ Upper Leg Numb	L / R	☐	☐	☐	☐
☐ Knee Pain	L / R	☐	☐	☐	☐
☐ Knee Numb	L / R	☐	☐	☐	☐
☐ Lower Leg Pain	L / R	☐	☐	☐	☐
☐ Lower Leg Numb	L / R	☐	☐	☐	☐
☐ Ankle Pain	L / R	☐	☐	☐	☐

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Auto Accident Forms

Symptom	L / R				
☐ Ankle Numb	L / R	☐	☐	☐	☐
☐ Foot Pain	L / R	☐	☐	☐	☐
☐ Foot Numb	L / R	☐	☐	☐	☐
☐ Dizziness		☐	☐	☐	☐

Symptom	Immediate	Few Hours	Next day	Later
☐ Nausea	☐	☐	☐	☐
☐ Tired all the time	☐	☐	☐	☐
☐ Irritable	☐	☐	☐	☐
☐ Unable to sleep	☐	☐	☐	☐

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Auto Accident Forms

The Neck Disability Index

Score__________

Name: ____ Date: _____________________

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 answer every section and mark in each section only the ***ONE*** box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the one 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 the worst 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 every day 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 weights without extra pain
☐I can lift heavy weights, but it gives extra pain
☐Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table
☐Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
☐I can lift very light weights
☐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 slight 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 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 headaches at all
☐I have slight headaches that come infrequently
☐I have moderate headaches that come infrequently
☐I have moderate headaches that come frequently
☐I have severe headaches that come frequently
☐I have headaches 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 concentrating when I want to
☐I have a great deal of difficulty concentrating when I want to
☐I cannot concentrate at all

Section 7 – Work

☐I can do as much work as I want to
☐I can do 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 do any work at all
☐I can't do any work at all

Section 8 – Driving

☐I can drive my car without any neck pain
☐I can drive my car as long as I want with slight pain in my neck
☐I can drive my car as long as I want with moderate pain in my neck.
☐I can't drive my car as long as I want because of moderate pain in my neck
☐I can hardly drive at all because of severe pain in my neck
☐I can't drive my car at all

Section 9 – Sleeping

☐I have no trouble sleeping
☐My sleep is slightly disturbed (less than 1 hour sleepless)
☐My sleep is mildly disturbed (1-2 hours sleepless)
☐My sleep is moderately disturbed (2-3 hours sleepless)
☐My sleep is greatly disturbed (3-5 hours sleepless)
☐My sleep is completely disturbed (5-8 hours sleepless)

Section 10 – Recreation

☐I am able to engage in all my recreation activities, with no neck pain at all
☐I am able to engage in all my recreation activities with some neck pain
☐I am able to engage in most, but not all, of my usual recreational activities because of pain in my neck
☐I am able to engage in few of my recreation activities because of pain in my neck
☐I can hardly do any recreation activities because of pain in my neck
☐I can't do any recreation activities at all

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Oswestry Disability Questionnaire

Score: __________

Name: ____ Date: _____________________

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but please just check one box that indicates the statement which most clearly 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 the worst 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 can manage most of my personal care
☐I need help every day in most aspects of self-care
☐I do not get dressed, wash with difficulty and stay in bed

Section 3 – Lifting

☐I can lift heavy weights without extra pain
☐I can lift heavy weights but it gives me extra pain
☐Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example, 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 very light weights
☐I cannot lift or carry anything

Section 4 – Walking

☐Pain does not prevent me walking any distance
☐Pain prevents me from walking more than 1 mile
☐Pain prevents me from walking more than .5 miles
☐Pain prevents me from walking more than .25 miles
☐I can only walk using a walker or crutches
☐I am in bed most of the time

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 30 minutes
☐Pain prevents me from sitting more than 10 minutes
☐Pain prevents me from sitting at all

Section 6 - Standing

☐I can stand as long as I want without extra pain
☐I can stand as long as I want but it gives me extra pain
☐Pain prevents me from standing for 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

Section 7 – Sleeping

☐My sleep is never disturbed by pain
☐My sleep is occasionally disturbed by pain
☐Because of pain I have less than 6 hours of sleep
☐Because of pain I have less than 4 hours of sleep
☐Because of pain I have less than 2 hours of sleep
☐Pain prevents me from sleeping at all

Section 8 – Sex Life (If applicable)

☐My sex life is normal and causes no extra pain
☐My sex life is normal but causes some extra pain
☐My sex life is 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

Section 9 – Social Life

☐My social life is normal and gives me no extra pain
☐My social life is normal but increases the degree of pain
☐Pain has no significant effect on my social life apart from limiting my more energetic interests, for example, sports.
☐Pain has restricted my social life and I do not go out as often
☐Pain has restricted my social life to my home
☐I have no social life because of pain

Section 10 – Travel

☐I can travel anywhere without pain
☐I can travel anywhere but it gives me extra pain
☐Pain is bad but I manage journeys over 2 hours
☐Pain restricts me to journeys of less than 1 hour
☐Pain restricts me to short, necessary journeys under 30 minutes
☐Pain prevents me from travelling except to receive treatment

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