

Motor Vehicle Accident Information

Patient Name: _____ Date of Accident: _____

General Information

Patient Location:

Check all that applies:

What was your location in the vehicle?	<input type="checkbox"/> Driver	<input type="checkbox"/> Passenger	
If passenger, what location?	<input type="checkbox"/> Front	<input type="checkbox"/> Middle	<input type="checkbox"/> Rear
	<input type="checkbox"/> Left	<input type="checkbox"/> Middle	<input type="checkbox"/> Right


Vehicle Description:

Check all that applies:

Type:	<input type="checkbox"/> Car	<input type="checkbox"/> Van	<input type="checkbox"/> Truck	<input type="checkbox"/> Bus	<input type="checkbox"/> SUV	<input type="checkbox"/> Motorcycle	<input type="checkbox"/> Other _____
Size:	<input type="checkbox"/> Compact	<input type="checkbox"/> Mid Size	<input type="checkbox"/> Full Size				
Action:	<input type="checkbox"/> Stopped	<input type="checkbox"/> Slowing	<input type="checkbox"/> Acceleration	<input type="checkbox"/> Cruising			
Speed:	_____ MPH						
Time of accident:	<input type="checkbox"/> Day light	<input type="checkbox"/> Dawn	<input type="checkbox"/> Dusk	<input type="checkbox"/> Dark			
Road Condition:	<input type="checkbox"/> Dry	<input type="checkbox"/> Damp	<input type="checkbox"/> Wet	<input type="checkbox"/> Snow	<input type="checkbox"/> Ice		
Visibility:	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor				

Impact Information:

Check all that applies:

What impacted the vehicle:	<input type="checkbox"/> Vehicle	<input type="checkbox"/> Object					
Object:	_____						
Vehicle Type:	<input type="checkbox"/> Car	<input type="checkbox"/> Van	<input type="checkbox"/> Truck	<input type="checkbox"/> Bus	<input type="checkbox"/> SUV	<input type="checkbox"/> Motorcycle	<input type="checkbox"/> Other: _____
Size:	<input type="checkbox"/> Compact	<input type="checkbox"/> Mid Size	<input type="checkbox"/> Full Size				
Damage to vehicle:	<input type="checkbox"/> Minimal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extensive	<input type="checkbox"/> Totaled	<input type="checkbox"/> Unsure		
Impact Location: Circle all that apply:							

During Impact Information:

Check all that applies:

Seat Belt Impact?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Brakes Applied?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Air Bag Deployed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seat Broken?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prepare for Accident:	<input type="checkbox"/> Un-Expected	<input type="checkbox"/> Expected	<input type="checkbox"/> Expected and Braced		
Head Rest Position:	<input type="checkbox"/> Low	<input type="checkbox"/> Mid	<input type="checkbox"/> High	<input type="checkbox"/> None	
Body Position:	<input type="checkbox"/> Straight	<input type="checkbox"/> Rotated Left	<input type="checkbox"/> Rotated Right	<input type="checkbox"/> Unsure	<input type="checkbox"/> Other _____
Body Thrown:	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Direction of Throw:	<input type="checkbox"/> Backwards	<input type="checkbox"/> Forward	<input type="checkbox"/> Outside	<input type="checkbox"/> Unsure	<input type="checkbox"/> Other _____
Head Position:	<input type="checkbox"/> Straight	<input type="checkbox"/> Rotated Left	<input type="checkbox"/> Rotated Right	<input type="checkbox"/> Forward	<input type="checkbox"/> Unsure
Head Motion:	<input type="checkbox"/> Forward Backwards	<input type="checkbox"/> Backwards Forward	<input type="checkbox"/> Right Left	<input type="checkbox"/> Left Right	
	<input type="checkbox"/> Unsure	<input type="checkbox"/> Other: _____			

Body Impact:

During the Accident:

<input type="checkbox"/> Left Hand	<input type="checkbox"/> Right Hand	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Mid Back	<input type="checkbox"/> Lower Back
<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Upper Torso	<input type="checkbox"/> Mid Torso	<input type="checkbox"/> Lower Torso
<input type="checkbox"/> Left Elbow	<input type="checkbox"/> Right Elbow	<input type="checkbox"/> Left Leg	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Head
<input type="checkbox"/> Left Foot	<input type="checkbox"/> Right Foot	<input type="checkbox"/> Left Knee	<input type="checkbox"/> Right Knee	
<input type="checkbox"/> Left Arm	<input type="checkbox"/> Right Arm	<input type="checkbox"/> Other: _____		
Numbness:	<input type="checkbox"/> Left Hand	<input type="checkbox"/> Right Hand	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Right Arm
	<input type="checkbox"/> Left Leg	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Foot	<input type="checkbox"/> Right Foot
	<input type="checkbox"/> Other: _____			

After Accident Information:

Immediately following Accident Symptoms:

<input type="checkbox"/> Dizzy/Dazed	<input type="checkbox"/> Upset	<input type="checkbox"/> Weak	<input type="checkbox"/> Nervous	<input type="checkbox"/> Headache	<input type="checkbox"/> Disoriented
<input type="checkbox"/> Unconscious	<input type="checkbox"/> Other: _____				

Patient Signature: _____

Date: _____

Medical Information:

Did you receive medical care? Yes No

If yes, please check off the following that apply:

Time of Accident: Next Day At time of Accident Later that Day Days Later: ____

Transportation: Drove Self Ambulance Other: _____

Went To: Chiropractor Family Dr. ER Urgent Care (Patient First)

Other: _____

Admitted to Hospital: No Yes How many days spent in hospital: _____

Test: X-Ray Lab work MRI CT Scan Other: _____

Treatment: Ice Pack Hot Pack Cervical Collar Medication

Other: _____

Previous Injuries

Previous Injuries/ Accidents: No Yes Specify: _____

Residual pain from Previous Injury/ Accidents: No Yes Specify: _____

Later Symptoms:

Head: Headache Dizziness Blurred Vision Light Headedness

Loss of Vision Fainting Loss of Memory Pain in Ear

Double Vision Other: _____

Neck: Pain in Neck Tilt Forward Bend Left Turn Left

Muscle Spasm Tilt Backward Bend Right Turn Right

Popping in Neck Other: _____

Patient Signature: _____

Date: _____

Shoulders: Pain in Joint Tension in Shoulder Muscle Spasms

Pain Across Shoulder Cant Raise Arms Above Shoulder Level

Cant Raise Arms Over Head Other: _____

Arms and Hands: Pain in Fingers Hands Cold Loss of Grip Strength

Pins and Needles in Hands Pins and Needles in Fingers

Numbness in Left Arm Numbness in Right Arm

Swollen Joints in Fingers Other: _____

Chest: Chest Pain Pain Around Ribs Shortness of Breath

Breast Pain Other: _____

Abdomen: Nervous Stomach Nausea Diarrhea

Gas Constipation Other: _____

Mid Back: Sharp Stabbing Mid Back Pain Pain from Font to Back

Dull Ache Pain in Kidney Area Muscle Spasms

Pain Between Shoulders Other: _____

Lower Back: Low Back Pain

Lower back pain is worse when: Working Sitting Lifting Bending

Coughing Standing Laying Down Muscle Spasms

Other: _____

Hips, Legs, & Feet: Pain and Needles in Legs Pain in Buttocks Pain down Leg

Pain in Hip Joint Feet Feel Cold Swollen Feet

Numbness in Toes Numbness of Leg Cramps in feet

Knee Pain Leg Cramps Cramps in Feet

Other: _____

Patient Signature: _____

Date: _____

General: Nervous Fatigue Irritable Depressed Cramping

Generally Feel Run Down Prostate Pain/Swelling

Difficulty Urinating Night Urination Irregularity

Loss of Sleep: _____ hrs per night

Loss of Weight: _____ lbs

Gain of Weight: _____ lbs

Other:

Brief Description of Accident in your words:

Patient Signature: _____

Date: _____

CAD Symptoms Questionnaire

Name: _____

Date: _____

Please check any symptoms you now have that you consider important.

- Vertigo (a severe form of unsteadiness that makes you have to stop moving completely for a while)
- Nausea caused by extremes of motion of the neck (i.e., full head turning or bending of the neck toward the chest)
- Pain or stiffness from neck to shoulders region(s)
- Electric shock-like sensations over the back of the head with certain motions of the neck.
- Inability to hold neck still for more than a few moments (restless neck syndrome)
- Occasional fainting or near fainting.
- Pain in the back (but not the front) of the back; neck stiffness.
- Neck sometimes locks or gets stuck in forward bending position.
- Neck sometimes locks or gets stuck when turning head right or left.
- Jaw joint pain, stiffness.
- Loss of sense of smell.
- Headaches
- Blurred vision
- Blurred vision in one eye, but not the other eye.
- Double vision or blurred vision.
- Dizziness, loss of balance, or feelings of unsteadiness.
- Difficulty with speech.
- Numbness or tingling in one or both upper extremities (arm, forearm, hand, fingers)
- Amnesia
- Back sometimes locks in forward bending positions-hard to straighten out.
- Numbness and tingling over spine (back) in either the neck or back regions
- Upper back pain; stiffness.
- Pain in one or both upper extremities (arm, forearm, hand, fingers)
- Numbness or tingling in both hands and both feet, but not elsewhere.
- Frequently drop objects.
- Lower back pain; stiffness.

On a scale of 0-10 please circle what level is relevant to you as to how whiplash has affected you.

1. How much **pain** do you have today?

0 1 2 3 4 5 6 7 8 9 10
no pain Worst pain imaginable.

2. How often do you experience **tiredness/fatigue** as a result of your whiplash injury/symptoms?

0 1 2 3 4 5 6 7 8 9 10
Not at all Always

3. How often do you experience **sadness/depression** as a result of your whiplash injury/symptoms?

0 1 2 3 4 5 6 7 8 9 10
Not at all Always

4. How often do you experience **anger** as a result of your whiplash injury/symptoms?

0 1 2 3 4 5 6 7 8 9 10
Not at all Always

5. How often do you experience **anxiety** as a result of your whiplash injury/symptoms?

0 1 2 3 4 5 6 7 8 9 10
Not at all Always

6. How has your condition **changed** over the past month?

-5 -4 -3 -2 -1 0 1 2 3 4 5
Much worse No change Much better

Neck Disability Index

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 box that most closely describes your problem.

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.

Personal Care (Washing, Dressing ect.)

- 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.

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 manage if they are conveniently positioned, 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 at the most.
- I cannot lift or carry anything at all.

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 the moderate pain in my neck.
- I can hardly read at all, because of the severe pain in my neck.
- I cannot read at all.

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 almost all the time.

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.

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.

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 the severe pain in my neck.
- I can't drive my car at all.

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 (2-3 hrs sleepless).
- My sleep is greatly disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

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 recreation 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.

Oswestry Disability Index (For Low Back)

Name: _____

Date: _____

This questionnaire has been designed to give the doctor information as to how your LOWER BACK 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 box that most closely describes your problem.

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.

Personal Care

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way or 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 or 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 and dressing without help.

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 manage if they are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights off the floor.
- 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 at the most.

Walking

- I have no pain on walking.
- I have some pain on walking, 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.

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 1/2 hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain right away.

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 for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain right away.

Sleeping

- I get no pain in bed.
- I get pain in bed, but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than $\frac{1}{4}$.
- Because of pain, my normal night's sleep is reduced by less than $\frac{1}{2}$.
- Because of pain, my normal night's sleep is reduced by less than $\frac{3}{4}$.
- Pain prevents me from sleeping well.

Social Life

- My social life is normal and gives me no 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, e.g., dancing, ect.
- 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.

Traveling

- I get no pain while traveling.
- I get some pain while traveling, but none my usual forms of travel makes it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling, which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but is defiantly getting better.
- My pain seems to be getting better, but Improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Roland-Morris (Low Back Pain)

Name: _____

Date: _____

Please read instructions: When your back hurts, you may find it difficult to some of the things you normally do. Mark only the sentences that describe you today.

- I stay at home most of the time because of my back.
- I change position frequently to try to get my back comfortable.
- I walk more slowly than usual because of my back.
- Because of my back, I am not doing any jobs that I usually do around the house.
- Because of my back, I use a handrail to get upstairs.
- Because of my back I lie down to rest more often.
- Because of my back, I have to hold on to something to get out of an easy chair.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly than usual because of my back.
- I only stand up for short periods of time because of my back.
- Because of my back, I try not to bend or kneel down.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all of the time.
- I find it difficult to turn over in bed because of my back.
- My appetite is not very good because of my back.
- I have trouble putting on my sock (or stockings) because of the pain in my back.
- I can only walk short distances because of my back pain.
- I sleep less well because of my back.
- Because of my back pain, I get dressed with that help of someone else.
- I sit down for most of the day because of my back.
- I avoid heavy jobs around the house because of my back.
- Because of back pain, I am more irritable and bad tempered with people than usual.
- Because of my back, I go upstairs more slowly than usual.
- I stay in bed most of the time because of my back.



Dr. Joel D. Feeman

**ASSIGNMENT OF PAYMENT
AND
SECURITY AGREEMENT FOR MEDICAL SERVICES**

For good and valuable consideration, the undersigned directs you, my insurance company, and/or my attorney, to pay directly to *New Life Chiropractic*, such sums as may be due and owing said office for services rendered to me, and to withhold such sums from any disability benefits, workers' compensation benefits or any other insurance benefits obligated to reimburse me, or from any settlement, judgment or verdict on my behalf as may be necessary to protect said office.

I hereby further give a lien to said office against any and all insurance benefits and proceeds of any settlement, judgment or verdict named herein, which may be paid to me as a result of injuries or illnesses for which I have been treated by said office. The undersigned does hereby assign and set over to said *New Life Chiropractic* a sum of money equal to that amount which *New Life Chiropractic* is entitled to payment for services rendered.

I understand that I remain personally responsible for the total amounts due to said office for their services, and I further understand and agree that this Assignment of Payment, Security Agreement for Medical Services, Lien, and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.

Dated _____

Patient's Name

Patient's Signature

Witness

X _____



**INSURANCE ASSIGNMENT AND INSTRUCTION
FOR DIRECT PAYMENT TO DOCTOR**

Patient: _____

I hereby instruct and direct that the Insurance Co., _____ is to pay by check made out and mailed to:

New Life Chiropractic
2051 Reed Rd.
Fort Wayne, IN 46815

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and New Life Chiropractic or me and mail directly to New Life Chiropractic as follows:

(Patient's Name)
C/O New Life Chiropractic
2051 Reed Rd.
Fort Wayne, IN 46815

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed by indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Signature of Policy Holder

Signature of Claimant if not Policy Holder

Date

Date

THE FOLLOWING AUTO ACCIDENT INFORMATION IS REQUIRED IN ORDER TO CARE FOR YOU UNDER A PERSONAL INJURY CASE:

YOUR AUTO INSURANCE INFORMATION:

Insurance Company _____

Address _____ City _____ State/Zip _____

Phone #: (_____) - ____ - ____.

Contact Person: _____

YOUR ATTORNEY INFORMATION:

Name _____

Address _____ City _____ State/Zip _____

Phone #: (_____) - ____ - ____.

CLAIM # _____

OTHER PERSON'S AUTO INSURANCE INFORMATION:

Insurance Company _____

Address _____ City _____ State/Zip _____

Phone #: (_____) - ____ - ____.

Contact Person: _____

Signature

Date