

LAKE NONA FAMILY CHIROPRACTIC

Automobile/PI Accident or Work Comp Questionnaire

Patient's Name

DOB

HR#:

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.

Thank you.

Please explain in detail how your accident happened. _____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____

Did you require post accident hospitalization? Yes/ No

Check symptoms you have noticed since the accident:

<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Buzzing in Ears	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Head Seems too Heavy	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Feet Cold	<input type="checkbox"/> Neck Stiff
<input type="checkbox"/> Pins and Needles in Arms	<input type="checkbox"/> Ears Ring	<input type="checkbox"/> Hands Cold	<input type="checkbox"/> Fainting
<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Face Flushed	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Pins and Needles in Legs	<input type="checkbox"/> Constipation	<input type="checkbox"/> Tension	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Numbness in Fingers	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Fever	<input type="checkbox"/> Irritability
<input type="checkbox"/> Numbness in Toes	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Cold Sweats
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Stomach Upset		

Symptoms other than above: _____

Where were you taken after the accident? _____

Hospitalized? Yes/ No If yes, admitted? _____ How long? _____

Name of Hospital _____

Name of Doctors _____

What treatment was given? _____

Was any other doctor consulted after your accident? Yes/ No

PAIN DISABILITY QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally Unable to work at all
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely Need help with all my personal care
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
3. Does your pain interfere with your traveling?
Travel anywhere I like Only travel to see doctors
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
4. Does your pain affect your ability to sit or stand?
No problems Can not sit/stand at all
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems Can not do at all
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems Can not do at all
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
7. Does your pain affect your ability to walk or run?
No problems Can not walk/run at all
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
8. Has your income declined since your pain began?
No decline Lost all income
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
9. Do you have to take pain medication every day to control your pain?
No medication needed On pain medication throughout the day
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
10. Does your pain force you to see doctors much more often than before your pain began?
Never see doctors See doctors weekly
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem Never see them
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference Total interference
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help Need help all the time
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension Severe depression/tension
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems Severe problems
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

Examiner

OTHER COMMENTS:

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.