

PATIENT HISTORY

Date: _____

(Legal) First Name _____ (Legal) MI _____ (Legal) Last Name _____ DOB _____ Age _____
Street _____ Apt. _____
City _____ State _____ Zip _____
Social Security # _____ Marital Status [] S [] M [] W [] D Spouse: _____

Language:

____ English ____ Spanish ____ Indian ____ Japanese ____ Chinese ____ Korean ____ French ____ German ____ Russian

Other: _____

Race/Ethnicity:

____ White ____ American Indian or Alaskan Native ____ Asian ____ Native Hawaiian/Other Pacific Islander ____
____ Black or African American ____ Hispanic or Latino ____ Decline to Answer

Contact Info: Home Phone: _____ Work Phone: _____ Cell: _____
Cell Carrier: _____ Email Home: _____
Email Work: _____
Contact Preference: [] Home Ph [] Work Ph [] Cell Ph [] Email Hm [] Email Wk [] Postal Mail

Emergency Contact: _____ Phone: _____
Who referred you to our office? _____ Phone: _____

Occupation: _____ Employer: _____
Employer Address: _____
City _____ Street _____ State _____ ZIP _____

Insurance Information: *A copy of your insurance card(s) will be made, in addition, please complete the information requested below:*

Are you the policy holder? [] Y [] N if No, who is? ____ Spouse ____ Parent ____ Employer ____ Other _____

Policy Holder's First Name _____ MI _____ Last Name _____ DOB _____

Policy Holder's Social Security # _____

Policy Holder's Employer: _____

Do you have secondary insurance? [] Y [] N if Yes, please complete the following:

Policy Holder's First Name _____ MI _____ Last Name _____ DOB _____

Policy Holder's Social Security # _____

Policy Holder's Employer: _____

Date: _____

First Name

MI

Last Name

Patient History

Please give a brief description of the problem(s) you are experiencing:

Is/Are the problem(s) getting better? Y N When did the problem(s) start? _____

What appears to be the initial cause? _____

Are you seeing any other providers for other problems or health conditions? Y N

Please list the problem(s), date problem(s) began and Provider(s) treating you for the condition(s):

Past History

Have you:

If yes, please list the date and name of the treating provider.

ever been diagnosed with Hypertension? Y N _____
been hospitalized in the last 5 years? Y N _____
been diagnosed with Diabetes? Y N _____
Type I _____ Type II _____

Do you smoke? Never Former Smoker Current/Every Day Smoker Current Some Day(s) Smoker

Vitals (for office use only) Height _____ Weight _____ Blood Pressure _____

Medications

What medications are you currently taking? (Please include all non-prescription and over the counter vitamins, herbs, minerals, etc.):
List Date, Brand Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by:
Please be as specific as possible.

Do you have allergies? Food Environmental Medication

List Type of Allergy and Reaction(s):

AUTO INSURANCE VERIFICATION

PATIENT NAME: _____

CLAIM NO (PATIENT INSURANCE): _____

DATE OF ACCIDENT: _____

DEDUCTIBLE: _____

MED PAY: _____ **PIP LIMITS:** _____

ADJUSTER'S NAME: _____

PHONE NO: _____ **EXT:** _____

FAX NO: _____

EMAIL: _____

INSURANCE COMPANY BILLING INFORMATION:

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

METHOD OF SUBMISSION: FAX _____ **MAIL** _____ **EMAIL** _____ **EDI** _____

NOTES REQUIRED? YES _____ **NO** _____

ONLINE CLAIM STATUS AVAILABLE? _____

AT FAULT? YES / NO

IF NO, AT FAULT INSURANCE CO: _____

CLAIM NO.: _____

ATTORNEY? Y / N

IF YES, ATTORNEY NAME: _____

PHONE: _____ **FAX:** _____

VERIFIED BY: _____ **DATE:** _____

Duties Performed Under Duress at Work and Home

Patient _____ Date _____ Date of Injury _____

Initial Update

Please check all that apply to your WORK because of the accident.

- | | |
|---|--|
| <input type="checkbox"/> I go to work but work in pain | <input type="checkbox"/> I work in pain because I have bills to pay |
| <input type="checkbox"/> I limit my work activities | <input type="checkbox"/> I can't take time off because I would lose my job |
| <input type="checkbox"/> Bending at work hurts | <input type="checkbox"/> I keep working so I don't lose status at company |
| <input type="checkbox"/> Stooping at work hurts | <input type="checkbox"/> My business would fail if I took time off |
| <input type="checkbox"/> Sitting at work hurts | <input type="checkbox"/> I believe in working even when I'm in pain |
| <input type="checkbox"/> Using the Computer at work hurts | <input type="checkbox"/> I feel obligated to work even though I'm in pain |
| <input type="checkbox"/> Pushing at work hurts | <input type="checkbox"/> My business would lose money if I took time off |
| <input type="checkbox"/> Pulling at work hurts | <input type="checkbox"/> My work is not as good as it was before accident |
| <input type="checkbox"/> Kneeling at work hurts | <input type="checkbox"/> My boss reprimanded me for poor performance |
| <input type="checkbox"/> I have lost status in my company | <input type="checkbox"/> I got a different job within the same company |
| <input type="checkbox"/> I have lost job security | <input type="checkbox"/> I got a different job in another company |
| <input type="checkbox"/> I didn't get a promotion | <input type="checkbox"/> I make less money than before the accident |
| <input type="checkbox"/> I don't enjoy work as much as before | <input type="checkbox"/> I cannot do the same work/job as before accident |
| <input type="checkbox"/> I doze off at work | <input type="checkbox"/> I can't concentrate as well at work |
| <input type="checkbox"/> I take unpaid time off work to go to Dr. | <input type="checkbox"/> I take paid time off to go to Dr. |
| <input type="checkbox"/> I daydream at work more than before | <input type="checkbox"/> I make mistakes at work I didn't used to |
| <input type="checkbox"/> I feel tired at work | <input type="checkbox"/> I hide my poor work performance from my boss |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Please check all that apply to your HOME/DOMESTIC duties because of the accident.

- | | |
|---|--|
| <input type="checkbox"/> My house is not as clean now | <input type="checkbox"/> I cannot take time off because I care for children |
| <input type="checkbox"/> My yard is not as neat now | <input type="checkbox"/> I have _____ children ages _____ |
| <input type="checkbox"/> My garden is not as productive now | <input type="checkbox"/> I had to hire a paid housekeeper |
| <input type="checkbox"/> I do yard work, but do it in pain | <input type="checkbox"/> I asked someone for unpaid housekeeping help |
| <input type="checkbox"/> I cannot do my normal yard work | <input type="checkbox"/> I had to hire a paid gardener |
| <input type="checkbox"/> I do house work, but do it in pain | <input type="checkbox"/> I asked someone for unpaid yard work help |
| <input type="checkbox"/> I cannot do my normal house work | <input type="checkbox"/> Mowing the lawn hurts me |
| <input type="checkbox"/> Doing laundry hurts me | <input type="checkbox"/> I cannot mow the lawn |
| <input type="checkbox"/> I cannot do laundry now | <input type="checkbox"/> Taking out the trash hurts me |
| <input type="checkbox"/> Washing dishes hurts me | <input type="checkbox"/> I cannot take out the trash |
| <input type="checkbox"/> I cannot wash dishes now | <input type="checkbox"/> I do not enjoy my gardening/yardwork like I used to |
| <input type="checkbox"/> Vacuuming hurts me | <input type="checkbox"/> I do not enjoy my housework like I used to |
| <input type="checkbox"/> I cannot vacuum now | <input type="checkbox"/> Gardening hurts me |
| <input type="checkbox"/> Cooking hurts me | <input type="checkbox"/> I cannot do my gardening at all since the accident |
| <input type="checkbox"/> I cannot cook now | <input type="checkbox"/> Others living with me do my share of the work now |
| <input type="checkbox"/> Washing the car hurts me | <input type="checkbox"/> Others living with me do my share of the yard work |
| <input type="checkbox"/> I cannot wash my car | <input type="checkbox"/> Others living with me do my share of the gardening |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Signature _____

Date _____

Patient Name _____ Date _____ File# _____

Please read: This questionnaire is designed to enable us to understand how much your lower back pain has affected your ability to manage your everyday activities. Please answer every Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement applies to you, but **PLEASE JUST CIRCLE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 - Pain Intensity

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain comes and goes and is severe.
- F. The pain is severe and does not vary much.

SECTION 2 - Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increase the pain but I manage to not change my way of doing it.
- D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do some washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- E. Pain prevents me from lifting heavy weights, but I manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weights at the most.

SECTION 4 - Walking

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than 1 mile.
- C. Pain prevents me from walking more than 1/2 mile.
- D. Pain prevents me from walking 1/4 mile.
- E. I can only walk while using a cane or on crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than 1 hour.
- D. Pain prevents me from sitting more than a 1/2 hour.
- E. Pain prevents me from sitting more than 10 minutes.
- F. Pain prevents me from sitting at all.

SECTION 6 - Standing

- A. I can stand as long as I want without pain.
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for longer than 1 hour without increasing pain.
- D. I cannot stand for longer than a 1/2 hour without increasing pain.
- E. I cannot stand for longer than 10 minutes without increasing pain.
- F. I avoid standing, because it increases the pain right away.

SECTION 7 - Sleeping

- A. I have no pain in bed.
- B. I have pain in bed, but it does not prevent me from sleeping well.
- C. Because of pain, my normal nights sleep is reduced by less than one-quarter.
- D. Because of pain, my normal nights sleep is reduced by less than one-half.
- E. Because of pain, my normal nights sleep is reduced by less than three-quarters.
- F. Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. I have hardly any social life because of the pain.

SECTION 9 - Traveling

- A. I have no pain while traveling.
- B. I have some pain while traveling, but none of my usual forms of travel make it any worse.
- C. I have extra pain while traveling, which compels me to seek alternative forms of travel.
- D. Pain prevents all forms of travel except that done lying down.
- E. Pain restricts all forms of travel

SECTION 10 - Changing Degree of Pain

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better or worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

Disability Index Score: _____ %

Patient Name _____ Date _____ File# _____

Please read carefully:

This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ONE CHOICE which applies to you. We realize you may consider that two of the statements in any section relate to you, but please just mark the one box which most closely describes your problem right now.

SECTION 1 - Pain Intensity

- A. I have no pain at the moment.
- B. The pain is very mild at the moment.
- C. The pain is moderate at the moment.
- D. The pain is fairly severe at the moment.
- E. The pain is very severe at the moment.
- F. The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (washing, dressing, etc.)

- A. I can look after myself without causing extra pain.
- B. I can look after myself normally but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help but manage most of my personal care.
- E. I need help every day in most aspects of self-care.
- F. I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 - Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights but it gives extra pain.
- C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.

SECTION 4 - Reading

- A. I can read as much as I want with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I can hardly read at all because of severe pain in my neck.
- F. I cannot read at all.

SECTION 5 - Headaches

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come infrequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches which come almost all the time.

SECTION 6 - Concentration

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty concentrating when I want to.
- F. I cannot concentrate at all.

SECTION 7 - Work

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

SECTION 8 - Driving

- A. I can drive without any neck pain.
- B. I can drive as long as I want with slight pain in my neck.
- C. I can drive as long as I want with moderate pain in my neck.
- D. I cannot drive as long as I want because of moderate pain in my neck.
- E. I can hardly drive at all because of severe pain in my neck.
- F. I cannot drive my car at all.

SECTION 9 - Sleeping

- A. I have no trouble sleeping.
- B. My sleep is slightly disturbed (less than 1 hr. sleepless).
- C. My sleep is mildly disturbed (1-2 hrs. sleepless).
- D. My sleep is moderately disturbed (2-5 hrs. sleepless).
- E. My sleep is greatly disturbed (3-5 hrs. sleepless).
- F. My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 - Recreation

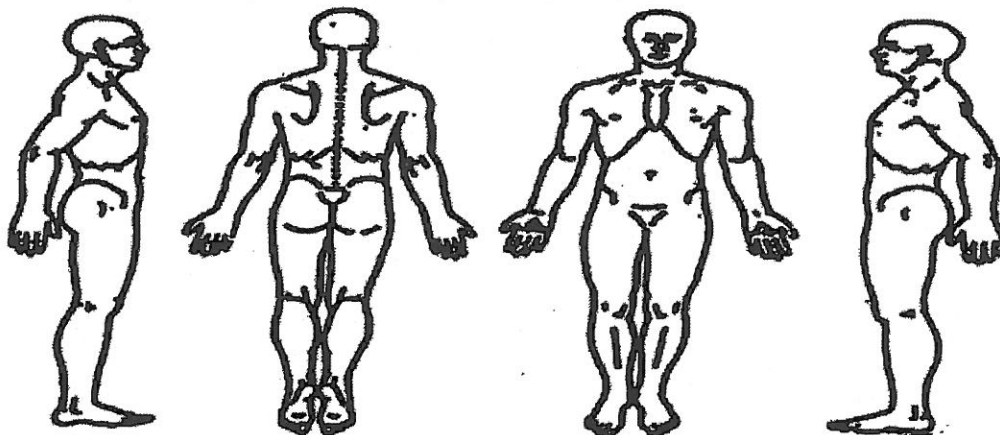
- A. I am able to engage in all my recreation activities with no neck pain at all.
- B. I am able to engage in all my recreation activities with some pain in my neck.
- C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
- E. I can hardly do any recreation activities because of pain in my neck.
- F. I cannot do any recreation activities at all.

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Date of Birth _____

Occupation _____

16. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

- Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain		
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer		
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

For Females Only

- Birth Control Pills
 Hormonal Replacement
 Pregnancy

20. List all prescription medications you are currently taking:

21. List all of the over-the-counter medications you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

24. What activities do you do outside of work?

25. Have you ever been hospitalized? No Yes

if yes, why _____

26. Have you had significant past trauma? No Yes

27. Anything else pertinent to your visit today? _____

Patient Signature _____

Date: _____

Name: _____

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What state did the accident occur in? _____
6. What city did the accident occur in? _____
7. What street or intersection were you on when the accident occurred? _____
8. What direction were you traveling in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the accident? if yes, please describe

11. Where were you sitting in the vehicle during the accident?

12. Did you know the accident was coming? _____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact, how fast was your vehicle moving? _____
16. At the time of impact, how fast was the other vehicle moving? _____
17. During and after the crash what happened to your vehicle? (circle all that apply)
 - kept going straight
 - kept going straight hitting a car in front
 - was hit by another vehicle
 - spun around
 - spun around and hit a stationary object
 - hit a stationary object
18. Did you lose consciousness during the accident? -yes _____ - no _____
19. How was your head positioned during the accident? _____
20. How was your torso positioned during the accident? _____
21. How were your hands positioned during the accident? _____
22. Did your head hit anything during the accident? -no _____ - yes, please describe _____
23. Did your face hit anything during the accident? -no _____ - yes, please describe _____
24. Did your shoulders hit anything during the accident? -no _____ - yes, please describe _____
25. Did your neck hit anything during the accident? -no _____ - yes, please describe _____
26. Did your chest hit anything during the accident? -no _____ - yes, please describe _____

27. Did your hips hit anything during the accident? -no - yes, please describe _____

28. Did your knees hit anything during the accident? -no - yes, please describe _____

29. Did your feet hit anything during the accident? -no - yes, please describe _____

30. What kind of headrest was in your vehicle?

- movable fixed headrest
- nonmovable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? - yes -no

33. Did you slide out of your seatbelt during the accident? _____

34. What was damaged in your vehicle? (Circle all that apply)

- | | | |
|------------------|--------------------|-----------------------|
| - windshield | - rear bumper | - mirror |
| - steering wheel | - front bumper | - knee bolster |
| - dashboard | - trunk | - back right door |
| - seat frame | - front left door | - completely totalled |
| - side window | - front right door | |
| - rear window | - back left door | |

35. Choose the items that dented inward

- floorboards - side door - dashboard

36. Choose the doors that would not open as a result of the accident

- front left - front right
- rear left - rear right

37. Did you go to the hospital? If no, why and do not answer 38-43

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized over night? _____

41. Circle what you were prescribed at the hospital

- pain medication - muscle relaxors - neck brace

42. Did you recieve any stitches for any cuts at the hospital? _____

43. Were x rays taken at the hosiptal? If yes, which area was taken?
