Dr. Mark C. Anken, D.C.

Personal Injury Questionnaire

Office Use:_____

Patient's Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Work #: _____ Cell #:_____

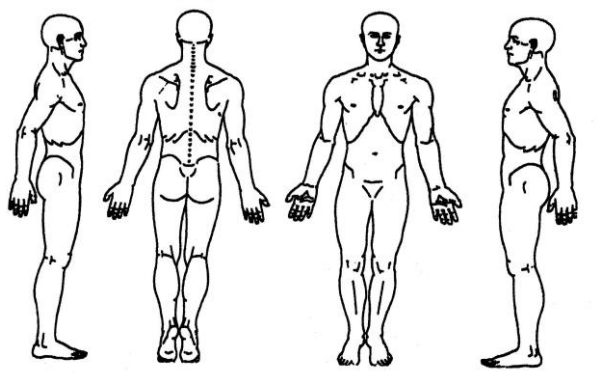
Sex: M F Date of Birth_____ Age_____ Social Security#_____

Primary Care Physician (PCP) _____ Health Ins: _____

Date of Injury: _____

Cause of Injury: _____

Personal Injury Complaints



Please place an "X" on these Figures to show where your Pain is Located.

Include symptoms of Tingling/Numbness

Patient Height :_____ **Weight:** _____

Symptom 1 (Please check only one symptom. *Additional symptom sections are available if needed***.)**

□ Headaches □ Neck Pain □ Jaw Pain □ Upper Back Pain □ Middle Back Pain □ Low Back Pain □ Shoulder Pain
□ Elbow Pain □ Forearm Pain □ Wrist Pain □ Hand Pain □ Thumb Pain □ Hip Pain □ Knee Pain □ Leg Pain
□ Ankle Pain □ Foot Pain □ Chest Pain □ Other _____

Is the symptom located **LEFT, RIGHT, CENTER or BILATERAL?** (Please circle all that apply.)

Intensity of Pain: (No Pain) **0 1 2 3 4 5 6 7 8 9 10** (Very Intense)

Frequency: _____% of awake time

Did you experience this symptom prior to your injury? Yes No

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What aggravates the symptom? (Check all that apply.)

□ Bending Neck Forward □ Bending Neck Backward □ Tilting head to Right □ Tilting Head to Left
□ Turning Head to Right □ Turning Head to Left □ Bending Forward at Waist □ Bending Backward at Waist
□ Tilting Left at Waist □ Tilting Right at Waist □ Twisting Left at Waist □ Twisting Right at Waist □ Sitting □ Standing
□ Getting up from seated position □ Lifting □ Any Movement □ Driving □ Walking □ Running □ Nothing
□ Changing Positions □ Chewing □ Other_____

What relieves the symptoms? (Check all that apply.)
□ Resting □ Ice □ Heat □ Stretching □ Exercise □ Massage □ Walking □ Pain Medication □ Muscle Relaxers
□ Nothing □ Other _____

Type of Pain: (Check all that apply.)
□ Sharp □ Dull □ Achy □ Burning □ Throbbing □ Piercing □ Stabbing □ Deep □ Nagging □ Shooting □ Stinging
□ Other _____

When is pain worse? (Check all that apply.) □ Morning □ Afternoon □ Evening □ Night □ None

Does the pain radiate? Yes No If YES, where does the pain radiate? (Check all that apply.)
□ Jaw □ New □ Low Back □ Shoulder □ Arm □ Elbow □ Forearm □ Wrist □ Hand □ Fingers □ Hip □ Buttock
□ Thigh □ Leg □ Knee □ Ankle □ Foot □ Toes □ Other: _____

Additional Symptoms? (Check any that apply.) □ Dizziness □ Loss of Range of Motion □ Visual Disturbance
□ Anxiety □ Depression

**Additional symptom sections are available if needed.*

Activities of Daily Living Under Duress

At work: (Check all that apply.) □ Lifting □ Bending □ Sitting □ Walking □ Computer Duties
□ Other: _____

At School: (Check all that apply.) □ Lifting □ Bending □ Sitting □ Walking □ Computer Duties
□ Other: _____

Household/domestic duties: (Check all that apply.) □ Vacuuming □ Taking Care of Children □ Cleaning □ Shopping
□ Preparing Meals □ Yard work □ Transportation □ Taking out the trash □ Other: _____

Sports: (Check all that apply.) □ Social □ Competitive □ Regional □ Other:_____

Patient's Name: _____ Date: _____
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Auto Accident Mechanism of Injury Form

1) Were you wearing a seatbelt? **Yes** / **No** What type: **Lap Belt** / **Shoulder Belt** / **Both**

2) What was your position in the car? (Circle) **Driver** / **Front Passenger** / **Left Rear** / **Right Rear**

If "Driver", were your hands on the steering wheel? **Both** / **Left** / **Right**

Did the airbags deploy? **Yes** / **No**

Did you strike another vehicle? **Yes** / **No** Did another vehicle strike your vehicle? **Yes** / **No**

3) What type and year of vehicle were you in? _____

4) What was the approximate speed of your vehicle when the accident occurred? _____ mph

5) Angle of Impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

If Second Collision – Angle of 2nd impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

- In relation to the back of your head, was your headrest set: **Low** / **Middle** / **High**
- Were you surprised by the impact? **Yes** / **No**
  If "NO", how did you brace? **With Hands** / **With Feet**
- Where was your head facing at the time of impact? **Straight Ahead** / **Left** / **Right** / **Behind**
- Were you leaning forward at the time of impact? **Yes** / **No**

6) What type and year of vehicle struck yours?_____

7) What was the approximate speed of the other vehicle when the accident occurred? _____ mph

8) Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision happened: _____

_____

_____

_____

9) Did you feel pain immediately after the accident? **Yes** / **No**

10) Were you rendered unconscious as a result of the accident? **Yes / No**

11) Did you strike anything in the vehicle at the time of impact? **Yes** / **No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

12) Did your seat break or bend? **Yes** / **No**

13) Immediately following the accident, how did you feel? (Circle all that apply)

Dizzy / **Dazed** / **Weak** / **Upset** / **Disoriented** / **Nervous** / **Nauseous** / **Other**: _____

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Police and Ambulance:

Was the accident reported to the police? **Yes** / **No**

Were traffic citations issued? **Yes** / **No** If "YES", to whom? _____

Did you go to the hospital? **Yes** / **No** If "YES", when? _____

If "YES", how did you get there? **Ambulance** / **Police Car** / **Private Transportation**

Were you admitted? **Yes** / **No** If "YES", how long? _____

Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None** / **X-rays** / **Pain Medication** / **Stitches /**
Muscle Relaxants / **Bandaged** / **Cervical Collar** / **Physical Therapy** / **Instructed Regarding Concussion** / **Instructed Regarding Sprains & Strains** / **Instructed to Call an Orthopedist** / **Instructed to Call a Private Physician** / **Referred to This Office** / **Other**: _____

What other doctor have you seen as a result of this injury? _____

Do you have difficulty in excessive: **Standing** / **Walking** / **Riding** / **Bending** / **Twisting**

Do you have difficulty in excessive lifting: **Light** / **Moderate** / **Heavy** / **Repetitive**

Symptoms other than above: _____

_____ _____
Patient Signature Date

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