Patient's Accident Account

Date of Accident _____ Time _____ AM/PM
Location of Accident or Injury_____
Type of Accident (Select One) □ Auto Collision □ Work Accident □ Other _____
Please Describe the Accident or Injury (in as much detail as possible):
_____
_____
_____

Auto Injury Questions:

Were you the (Select One):	□ Driver	□ Passenger	□ Pedestrian		
Were you struck from (Select One):	□ Behind	□ Front	□ Left Side	□ Right Side	□ Parked
Did your car strike others involved:		□ Yes	□ No		
Did the other car strike yours:		□ Yes	□ No		
Did you have a seat belt on:		□ Yes	□ No		
Did any part of your body strike the car:	□ Yes	□ No	Which? _____		
Were traffic citations issued to you:		□ Yes	□ No		
Issued to the drivers:		□ Yes	□ No		
To the driver of the car you were in:		□ Yes	□ No		

Work Injury Questions:

Was your employer notified:	□ Yes	□ No	
Did the employer refer you anywhere	□ Yes	□ No	

Please Describe How You Felt After the Accident (in as much detail as possible):
_____
_____
_____

Please Read Carefully & Check Any Symptoms That You Have Noticed Since the Accident or Injury?

□ Headache	□ Dizziness	□ Loss of Memory	□ Ringing in Ears
□ Neck Pain	□ Head Seems Heavy	□ Face Flushed	□ Loss of Balance
□ Neck Stiff	□ Pins and Needles in Arms	□ Pins & Needles in Legs	□ Fainting
□ Sleeping Problems	□ Numbness in Fingers	□ Numbness in Toes	□ Loss of Smell
□ Back Pain	□ Shortness of Breathe	□ Upset Stomach	□ Loss of Taste
□ Nervousness	□ Light Bothers Eyes	□ Tension	□ Constipation
□ Irritability	□ Buzzing in Ears	□ Depression	□ Diarrhea
□ Chest Pain	□ Cold Hands	□ Lightheadedness	□ Cold Sweats
□ Fatigue	□ Cold Feet	□ Fever	□ _____
□_____	□_____	□ _____	□ _____

Did you feel any popping, tearing or ripping in your neck or back?		□ Yes	□ No
Do you have any bruises?	□ Yes	□ No	Where? _____
Have you been treated before for any of these symptoms?		□Yes	□ No
Did you go to the Emergency Room?	□ Yes	□ No	
Were you Examined?	□ Yes	□ No	
Were you X-Rayed?	□ Yes	□ No	
Was there treatment given?	□ Yes	□ No	
Medication?	□ Yes	□ No	
Have you seen any other doctors?	□ Yes	□ No	Who? _____
Have you lost any days from work	□ Yes	□ No	How many? _____

Patient Signature: _____ Date: _____

Printed Name: _____

PAIN DISABILITY QUESTIONNAIRE

Patient Name: _____ Date: _____

Instructions: These questions ask your view about how you 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 — Cannot do 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 — Cannot 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 — Cannot 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 — Cannot walk/ or 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 you 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 your doctors much more often than before you 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 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, 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

Voluntary Irrevocable Physician's Lien

To: _____

Re: Patient's Name: _____ Accident Date: _____

For and in consideration of the professional services I am about to receive or am receiving from you, to the extent of you, to the extent of your unpaid charges, I hereby grant you a voluntary and irrevocable lien against my share of the proceeds of any settlement or award resulting from the disposition if any claim which I may have arising from the captioned accident in which I was involved.

I hereby direct any attorney to recognize and honor this lien and to pay you directly from the proceeds allocated to me in his attorney trust account at the time he receives them. I have personally served my attorney with a copy of this lien and as principal have put my attorney, as my agent, on notice regarding his responsibility in paying you.

I hereby agree never to rescind or amend this lien and hereby agree to release you and my attorney from any claims whether in law or at equity which I may have resulting from the interpretation of this lien.

Should there be no settlement or award, I agree to remain personally responsible to pay your charges.

Name of Patient: _____ Signature: _____

Address of Patient: _____ Date: _____

_____

Acknowledgement of Lien

I hereby acknowledge the within lien and agree to be strictly bound by the terms thereof to the benefit of the physician with the understanding that the physician is placing reliance theron.

Name of Attorney: _____ Signature: _____

Address of Attorney: _____ Date: _____

_____