AUTO ACCIDENT INTAKE FORM

Today's Date:_____

Patient's Name:_____

Names of other people in car with you:_____

Patient's Insurance Company _____

Adjustor:_____ Phone:_____

Claim Number:_____ Medpay Limit:_____

Other Driver's Name: _____

What type of vehicle hit you (SUV, car, pickup, van)? _____

Other Driver's Insurance Company _____

Adjustor:_____ Phone:_____

Claim Number:_____

Facts of the Collision

Date of Collision:_____ Time:_____ Day of week:_____

Weather (Sunny, rainy, snowing, icy, etc…) :_____

What street/intersection: _____ City/County:_____

Description of accident/event:_____

_____

_____

_____

_____

_____

_____

Did your vehicle hit/get pushed into into anything after the collision? If yes, what? _____

What type of vehicle were you in (SUV, car, pickup, van)? _____

Who is the owner of the vehicle you were in?:_____

Approximate speed – your vehicle:_____ Other Vehicle:_____

If you were the driver, your foot position (brake, clutch, gas, other, etc…):_____

What parts of the car you were in, were damaged?:_____

Cost of repairs to car you were in? $_____

Where did you obtain the damage estimate?_____

Where was the vehicle repaired?_____

Damages to the other driver's car:_____

Did the Police arrive: YES NO Which police department?_____

Was anyone Cited: YES NO If YES, what for?_____

Statements made at the scene by you or the other party: _____

_____

_____

Have you made any statements to any insurance company or anyone else:_____

Do you, or anyone else, have photographs of the accident scene, automobiles, or your injuries: YES NO

If YES, who?_____

Were any vehicles towed from the scene? YES NO If YES, whose vehicle was towed? MINE OTHER

Do you believe that any of the following were defective and resulted in the accident itself or a worsening of your injuries? ROAD SIGNS ROADS TRAFFIC SIGNAL BRAKES SEAT BELT AIRBAG SEAT

Injuries, Impairment & Damages

List your injuries as a result of the Accident/Event:_____

_____

_____

_____

_____

_____

_____

Which of the following do you suffer from now, which you did not have prior to the accident**? (circle all that apply)**

Headaches	Dizziness	Difficulty Concentrating
Long Term Memory Loss	Short Term Memory Loss	Amnesia
Blackouts Since Collision	Forgetting Numbers	Relationship Difficulties
Reading Problems	Writing Problems	Irritability
Apathy	Sleep Disturbances	Intolerance to Heat/Cold
Personality Changes	Attention Impairment	Emotional Difficulties
Blurred/Changed Vision	Sensitivity to Light	Missing Periods of Time
Intolerance to Alcohol	Speech Difficulties	Nausea/Vomiting
Impaired Comprehension/Learning	Extreme Thirst	Fatigue
Menstrual Irregularities	Tinnitus (ringing in ears)	Noise Intolerance
Loss of Coordination	Bumping Into Objects in View	Loss of Balance
Hearing Loss	Vertigo (spinning sensation)	Anxiety
Depression	Flashbacks to Accident	Nightmares
Unusual Behavior	Panic Attacks	Weight loss/gain ____lbs
Social Withdrawal/Anxiety in Crowds	Changes in taste/smell	Jaw/Chewing Pain
"Clunk" sound when moving neck	Thoughts of death/Suicide	Clicking in Jaw

Numbness/Tingling/Weakness in arms: Right Left Pain level 1-10_____

Numbness/Tingling/Weakness in Legs: Right Left Pain level 1-10_____

Were you wearing a seatbelt? _____ Injuries cause by seatbelt :_____

Head/Body Position: Straight ahead Rotated Right Rotated Left Looking up Looking down

Type of impact: Head on Right Side Left Side Angle Rear Ended

Where was the headrest located? Mid Neck Mid Head Upper Head None

Did your head or body strike anything in the car, if so, what ? _____

Did you get a concussion?_____ Did you lose consciousness?_____

Feelings immediately after the accident (shocked, stunned, scared..etc)? _____

Were you **Aware** or **Unaware** the accident was going to happen? _____

Did items in the car get displaced? If so, what? _____

Did the airbags deploy: _____ Did the seats break?_____

Were you taken to a hospital by an ambulance? If so, company name: _____

Hospitalizations or outpatient surgeries related to accident:

Physician Facility Date(s) Details

1._____

2._____

3._____

4._____

Treating Physicians/Specialists/Therapists (related only to this collision)

Provider/Facility Address Phone

1._____

2._____

3._____

4._____

What are you not able to do anymore as a result of this accident?_____

_____

Employment

Employer at time of accident: _____

Any loss of work due to accident, if so, what were they?_____

Job Title:_____

Job Duties:_____

_____

Prior Medical History

Who is your Primary Care Physician?_____

Address:_____ Phone:_____

List, as carefully and accurately as you can, all injuries, illnesses or medical conditions you have had in your life, even if they have no similarities to the injuries you sustain in this collision, including past Motor Vehicle Accidents and Worker's Compensation Claims. Include the approximate dates, the cause of the inquiry, the doctors who treated you, and whether or not you fully recovered from those problems. If any lawsuit or claim was made for those injuries, please so state.

_____

_____

_____

_____

_____

_____

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

Name: _____ Date:_____

Loss of Enjoyment of Life Index

This form is to determine whether you have lost the enjoyment of certain activities in your life, or lost status or skills in these activities as a result of you r injuries from this collision.

Work Activities

☐ I have lost enjoyment in performing my job as a result of the injuries caused in this collision.

My employment status at the time of the collision is best described as:

☐ Full time employed
☐ Part time employed
☐ Casual Employee
☐ Seasonal Employee
☐ Not Employed

If your answer is Full Time, Part Time, or Casual Employee, which of the following categories best describes your work capacity since the collision:

☐ I resumed my same job and duties
☐ I resumed my same job with Lighter Duties
☐ I resumed Alternate Duties Within the Same Industry
☐ I changed industries
☐ I have not resumed work

The injuries from this collision have had the following effects on my work:

☐ I have lost status within the company
☐ I have lost job security
☐ I have lost potential promotions
☐ I have difficulty in performing my normal job duties
☐ I am unable to perform my pre-accident job

Domestic Activities

☐ Not Applicable
☐ I have lost enjoyment in performing my domestic activities as a result of the injuries caused in this collision
☐ I have experienced a loss of enjoyment with the following activities inside my home, since the collision
  ☐ Laundry
  ☐ Dishwashing
  ☐ Vacuuming
  ☐ Washing Windows
  ☐ Cleaning
  ☐ Preparing Meals
  ☐ Other:_____

Household activities

☐ I have lost enjoyment in performing my household activities, outside the home, as a result of the injuries caused in this collision
☐ I have experienced problems with the following activities outside my home
  ☐ Painting the outside of the house
  ☐ Landscaping
  ☐ Mowing the grass
  ☐ Trimming the bushes/trees
  ☐ Washing windows
  ☐ Gardening
  ☐ Taking out the Trash

- ☐ Washing the car(s)
- ☐ Maintaining the car(s)
- ☐ Maintaining yard equipment
- ☐ Doing other external house work, specify:_____

Studies/Educational Activities

- ☐ Not Applicable
- ☐ I have lost enjoyment in performing my educational activities as a result of the injuries caused by this collision
  - ☐ I am no longer able to attend school
  - ☐ I have dropped to part time
  - ☐ My grades have dropped
  - ☐ I have been forced to change schools due to the injuries

Before the collision I was attending

- ☐ High school
- ☐ Apprenticeship studies
- ☐ Technical college
- ☐ University, specify: _____
- ☐ Correspondence Course
- ☐ Graduate College/University, specify College and Degree:_____

I am now attending:

- ☐ High school
- ☐ Apprenticeship studies
- ☐ Technical college
- ☐ A different University, specify: _____
- ☐ Correspondence Course

Hobby Activities

- ☐ I have lost enjoyment in performing hobby activities as a result of the injuries caused in this collision

Activity #1 _____

Prior to the collision, I performed this activity at the following level:

- ☐ Informal and amateur
- ☐ Competitive
- ☐ Semi-Professional
- ☐ Professional

Prior to this collision

- ☐ I did not make money with this hobby
- ☐ I made $_____/month on average with this hobby, as reported to the IRS

After this collision, I performed this hobby activity at the following level

- ☐ I can't perform this hobby at all
- ☐ Informal and amateur
- ☐ Competitive
- ☐ Semi-Professional
- ☐ Professional

After this collision

- ☐ I did not make money with this hobby
- ☐ I made $_____/month on average with this hobby, as reported to the IRS

Duration of symptoms

- ☐ I did not enjoy this activity for __ weeks
- ☐ My doctors have instructed me that my ability to enjoy this activity without pain is a permanent condition
- ☐ My problems in enjoying this activity is ongoing, but my doctors have not instructed me that the condition(s) is permanent

Activity #2 _____

Prior to the collision, I performed this activity at the following level:

- ☐ Informal and amateur
- ☐ Competitive
- ☐ Semi-Professional
- ☐ Professional

Prior to this collision

- ☐ I did not make money with this hobby
- ☐ I made $_____/month on average with this hobby, as reported to the IRS

After this collision, I performed this hobby activity at the following level

- ☐ I can't perform this hobby at all
- ☐ Informal and amateur
- ☐ Competitive
- ☐ Semi-Professional
- ☐ Professional

After this collision

- ☐ I did not make money with this hobby
- ☐ I made $_____/month on average with this hobby, as reported to the IRS

Duration of symptoms

- ☐ I did not enjoy this activity for _ _ weeks
- ☐ My doctors have instructed me that my ability to enjoy this activity without pain is a permanent condition
- ☐ My problems in enjoying this activity is ongoing, but my doctors have not instructed me that the condition(s) is permanent

Sports Activity #1 _____

Prior to the collision, I performed this sport at the following level:

- ☐ Informal / Social / amateur
- ☐ Competitive
- ☐ Regionally Recognized
- ☐ Semi-Professional
- ☐ Professional

Prior to this collision

- ☐ I did not make money with this sports activity
- ☐ I made $_____/month on average with this sports activity, as reported to the IRS

After this collision, I performed this sports activity at the following level

- ☐ Informal / Social / amateur
- ☐ Competitive
- ☐ Regionally Recognized

☐ Cannot play the original sport
☐ Cannot play any sports

After this collision

☐ I did not make money with this sports activity
☐ I made $_____/month on average with this sports activity, as reported to the IRS

Duration of symptoms

☐ I did not enjoy this activity for___ weeks
☐ My doctors have instructed me that my ability to enjoy this activity without pain is a permanent condition
☐ My problems in enjoying this activity is ongoing, but my doctors have not instructed me that the condition(s) is permanent

Vacationing / Travel Activities

☐ I have lost enjoyment in traveling activities as a result of injuries caused in this collision
☐ I have been unable to engage in any car travel since the collision, due to my injuries
☐ I have been unable to engage in any plane travel since the collision, due to my injuries
☐ I have been unable to engage in any train travel since the collision, due to my injuries
☐ I have been unable to engage in any boat travel since the collision, due to my injuries

Prior to this collision I performed **Business Travel** at the following level:

☐ Yearly
☐ Seasonal
☐ Quarterly
☐ Monthly
☐ _____

After this collision, I altered my business travel in the following way:

☐ I cancelled the travel plans
☐ I didn't make the normal travel plans
☐ I altered the travel plans due to the injury
☐ I went, but with an increased level of pain
☐ I went, but was impaired by my activities
☐ I went and had minimal trouble
☐ I went and had no trouble

Prior to this collision I performed **Pleasure Travel** at the following level:

☐ Yearly
☐ Seasonal
☐ _____

After this collision, I altered my business travel in the following way:

☐ I cancelled the travel plans
☐ I didn't make the normal travel plans
☐ I altered the travel plans due to the injury
☐ I went, but with an increased level of pain
☐ I went, but was impaired by my activities
☐ I went and had minimal trouble
☐ I went and had no trouble

Name _____ Date_____

Duties Under Duress Index

Have you continued to do any of the following activities despite the pain caused by your collision?

Work

- ☐ Not Applicable

A. Why have you continued to work?

- ☐ I would lose my job if I took time off
- ☐ I couldn't support my family otherwise
- ☐ I don't believe in taking time off even when I was or in pain
- ☐ My business would fail if I did not work
- ☐ I cannot take time off – because I care for my own children
- ☐ Other:_____

B. I have experienced the following changes in my ability to perform at work:

1. Mobility/Stability Problems
   - ☐ Climbing
   - ☐ Kneeling
   - ☐ Lifting
   - ☐ Walking for long periods
2. Dexterity Problems
   - ☐ Finger Movements
   - ☐ Wrist Movements
3. Problems with Fatigue Yes or No
4. Postural Difficulties
   - ☐ Bending
   - ☐ Standing for long periods
   - ☐ Sitting for long periods
   - ☐ Stooping
5. Problems with Anxiety Yes or No
6. Problems with Depression Yes or No
7. Problems with Vertigo or Spinning Sensations
   - ☐ Dizziness
   - ☐ Giddiness
   - ☐ Sensation of irregular motion
   - ☐ Sensation of whirling motion
8. Problems with Tinnitus or Ringing in the ears Yes or No
9. Problems with Reduced Concentration
   - ☐ Can't concentrate
   - ☐ Can't think properly
   - ☐ Making mistakes

C. Duration of symptoms

- ☐ I experienced problems during my normal work activities for _____ weeks
- ☐ My doctors have instructed me that my inability to perform my normal pre-accident work activities without pain is a permanent condition
- ☐ My problems in performing my normal work activities is ongoing, but my doctors have not instructed me that the condition is permanent

Domestic Duties

A. I have experienced pain while performing the following activates INSIDE my home, but have done them anyway
   - ☐ Laundry
   - ☐ Dishwashing
   - ☐ Vacuuming
   - ☐ Washing Windows
   - ☐ Cleaning
   - ☐ Preparing Meals

B. Due to my injuries, I have brought in the following assistance:
   - ☐ Paid Housekeeper
   - ☐ Unpaid Assistance
   - ☐ None

C. My family status would best be described as
   - ☐ Single
   - ☐ Single parent at home
   - ☐ Spouse
   - ☐ Spouse and Children at home

   Childrens' ages: _____

D. Domestic Assistance
   - ☐ I do not receive domestic assistance
   - ☐ I do receive domestic assistance

E. Duration of symptoms
   - ☐ I experienced problems during my normal domestic activities for _____ weeks
   - ☐ My doctors have instructed me that my inability to perform my normal pre-accident domestic activities without pain is a permanent condition
   - ☐ My problems in performing my normal domestic activities is ongoing, but my doctors have not instructed me that the condition is permanent

Student/Educational Duties

- ☐ Not Applicable
- ☐ At the time of the collision, my education would best be described as:
  - ☐ High School
  - ☐ Apprentice Studies
  - ☐ Technical College
  - ☐ University
  - ☐ Correspondence Course

- ☐ My attendance before the collision is best described as
  - ☐ Full Time
  - ☐ Part Time

A. As a student, I have experienced problems with the following activates since the accident
   - ☐ Carrying Books
   - ☐ Sitting in classes
   - ☐ Looking down to read textbooks
   - ☐ Other:_____

B. I have experienced the following changes in my ability to perform at school as a result of injuries sustained in the accident:
   1. Mobility/Stability Problems
      - ☐ Climbing
      - ☐ Kneeling
      - ☐ Lifting
      - ☐ Walking for long periods
   2. Dexterity Problems
      - ☐ Finger Movements
      - ☐ Wrist Movements
   3. Problems with Fatigue Yes or No
   4. Postural Difficulties
      - ☐ Bending
      - ☐ Standing for long periods
      - ☐ Sitting for long periods
      - ☐ Stooping
   5. Problems with Anxiety Yes or No
   6. Problems with Depression Yes or No
   7. Problems with Vertigo or Spinning Sensations
      - ☐ Dizziness
      - ☐ Giddiness
      - ☐ Sensation of irregular motion
      - ☐ Sensation of whirling motion
   8. Problems with Tinnitus or Ringing in the ears Yes or No
   9. Problems with Reduced Concentration
      - ☐ Can't concentrate
      - ☐ Can't think properly
      - ☐ Making mistakes

External Household

A. I have experienced problems with the following activities OUTSIDE my home
   - ☐ Painting the outside of the house
   - ☐ Landscaping
   - ☐ Mowing the grass
   - ☐ Trimming the Bushes/trees
   - ☐ Washing Windows
   - ☐ Gardening
   - ☐ Taking out the Trash
   - ☐ Washing the car(s)
   - ☐ Maintaining the car(s)
   - ☐ Maintaining yard equipment
   - ☐ Other:_____

B. Duration of symptoms

- ☐ I experienced problems during my normal household activities for _____ weeks
- ☐ My doctors have instructed me that my inability to perform my normal pre-accident household activities without pain is a permanent condition
- ☐ My problems in performing my normal household activities is ongoing, but my doctors have not instructed me that the condition is permanent