

CONFIDENTIAL CLIENT QUESTIONNAIRE

Name: _____ Date: _____

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

Weather (sunny, rainy, snowing, etc) _____

Road conditions (wet, dry, icy, etc) _____

What streets did it happen on? _____ County: _____

Describe accident in your own words? (Please draw a diagram of what happened on the back of this page.) _____

Car you were riding in. (year, make, model) _____

Other cars involved (year, make, model): _____

Your Insurance Company: _____

Address: _____

Your policy number: _____

Claim Number: _____

Your Insurance Adjuster: _____ Phone #: _____

What parts of the car were damaged? _____

Cost of repair? _____ Do you have a damage estimate? _____

Were you	<input type="checkbox"/> Driver	<input type="checkbox"/> Passenger	<input type="checkbox"/> Pedestrian	Passenger Position	<input type="checkbox"/> Front	<input type="checkbox"/> R. Rear	<input type="checkbox"/> L. Rear
Was the Impact from:	<input type="checkbox"/> Front	<input type="checkbox"/> Right Side	<input type="checkbox"/> Left Side		<input type="checkbox"/> Rear		
At impact, were you looking:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Straight ahead				
Were hands on steering wheel?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Foot on brake	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headrest	<input type="checkbox"/> Yes <input type="checkbox"/> No
Were you braced for impact?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seat belts on	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shoulder harness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If shoulder restraint, was it shoulder/lap combination:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shoulder only	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Where in car were you after accident; _____			Did you strike anything in vehicle at impact?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If yes, specify:	<input type="checkbox"/> Steering Wheel	<input type="checkbox"/> Dashboard	<input type="checkbox"/> Windshield	<input type="checkbox"/> Side Door	<input type="checkbox"/> Other _____		
Part(s) of body which hit above part of car:							
	L R	L R	L R	L R	L R	L R	L R
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name(s) of people in your car:	1. _____		2. _____		3. _____		
Was there police investigation at scene?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Citation Issued	<input type="checkbox"/> Yes	<input type="checkbox"/> No	To Whom?	_____

YOUR INJURIES

Were you wearing a seat belt? _____ Shoulder harness? _____

What was the position of your head rest?

_____ shoulders _____ middle of neck _____ bottom of ears
_____ top of ears _____ above ears _____ top of head

What was the position of your body at time of impact?

_____ looking ahead _____ looking right _____ looking left
_____ looking in mirror _____ other _____

Did your head or body strike anything in the car? _____

What? _____

Did you lose consciousness? _____

Did items in the car get displaced? What? _____

How did you feel right away or soon thereafter? _____

Was an ambulance called?(if so which hospital were you transported to)? _____

Did you go to urgent care/hospital? _____

Were x-rays taken? _____ Diagnosis _____

Treatment rendered _____

When released? _____

Recommendations/home care _____

What doctors and hospitals have you seen for your injuries? Please list their names, addresses, phone numbers and when you have seen them.

What activities at work and at home did you typically do before the collision? _____

Have you lost any time from work because of this accident?

Yes _____ No _____

Dates from _____ to _____

Totally disabled from _____ to _____

Partially disabled from _____ to _____

Do you have an attorney who has advised you in this case? ___ Yes ___ No

Name: _____ Address: _____ phone _____

Indicate your ability to perform the following activities using codes N=

Normal, L= Limited, D= Difficult, P= Painful, U= Unable.

_____ coughing or sneezing	_____ sitting at table	_____ stooping	_____ climbing
_____ getting into/out of car	_____ lying on back	_____ gripping	_____ lying flat on stomach
_____ bending forward to brush teeth	_____ kneeling	_____ pushing	_____ lying on side w/knees bent
_____ turning over in bed	_____ balancing	_____ pulling	_____ bending over forward
_____ walking short distances	_____ dressing self	_____ reaching	
_____ standing for more than 1 hour	_____ sleeping	_____ sex activity	

I hereby authorize King Chiropractic Clinic to release medical information if necessary to process this claim.

Name: _____ Date: _____

Concussion?	Yes ___	No ___		
Headaches?	Yes ___	No ___		
Dizziness?	Yes ___	No ___		
Nauseas?	Yes ___	No ___		
Loss of Balance?	Yes ___	No ___		
Ringing in ears?	Yes ___	No ___		
Blurred vision?	Yes ___	No ___		
Loss of memory?	Yes ___	No ___		
Fluid in ears?	Yes ___	No ___		
Vomiting?	Yes ___	No ___		
Jaw pain?	Yes ___	No ___		
Clicking in jaw?	Yes ___	No ___		
Eating/chewing difficulty?	Yes ___	No ___		
Neck pain?	Yes ___	No ___		
Shoulder pain?	Yes ___	No ___		
Back pain?	Yes ___	No ___		
Hip pain?	Yes ___	No ___		
Numbness or tingling in the arms/hands/fingers (R or L)?			Yes ___	No ___
Numbness or tingling in the legs and/or feet (R or L)?			Yes ___	No ___

IMPAIRED ACTIVITIES (Circle those that apply)

SPORTS	aerobic exercise	archery	backpacking	bowling
badminton	baseball	basketball	basketry	bicycling
boxing	card playing	camping	dancing	fencing
fishing	flying	football	gardening	golf
handball	gymnastics	healthclubs	hockey	hunting
judo	horseback riding	ice skating	karate	painting
pottery	jogging/running	photography	raquetball	rafting
yoga	mountain climbing	snow skiing	sailing	tennis
soccer	rowing/boating	softball	water skiing	swimming
walking	musical instruments	volleyball	weight lifting	

DAY TO DAY ACTIVITIES

dressing	bathing/showering	bending	brushing teeth	cooking
holidays	dining out	ironing	housecleaning	movie going
laundry	sexual relations	lifting	church events	eating
moving	shampooing hair	reading	shaving	shopping
sitting	watching TV	sleeping	social events	standing
traveling	car washing	vacations	yard work	child care

WORK-RELATED ACTIVITIES

sitting	standing	telephoning	computer work	lifting
reading	bending	typing	writing	

Neck Index

American Chiropractic Network, Inc.

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Patient Name _____

Date _____

This questionnaire will give the doctor information about how your neck condition affects your everyday life. Please answer every section and mark only the one statement that applies to you. If two statements in one section relate to you, please mark the statement which most closely describes your problem.

Pain Intensity

- 0-I have no pain at the moment.
- 1-The pain is very mild at the moment.
- 2-The pain comes and goes and is moderate.
- 3-The pain is fairly severe at the moment.
- 4-The pain is very severe at the moment.
- 5-The pain is the worst imaginable at the moment.

Sleeping

- 0-I have no trouble sleeping.
- 1-My sleep is slightly disturbed (less than 1 hr. sleepless)
- 2-My sleep is mildly disturbed (1-2 hrs sleepless)
- 3-My sleep is moderately disturbed (2-3 hrs sleepless)
- 4-My sleep is greatly disturbed (3-5 hrs sleepless)
- 5-My sleep is completely disturbed (5-7 hrs sleepless)

Reading

- 0-I can read as much as I want with no neck pain.
- 1-I can read as much as I want with slight neck pain.
- 2-I can read as much as I want with moderate neck pain.
- 3-I can not read as much as I want because of moderate neck pain.
- 4-I can hardly read at all because of severe neck pain.
- 5-I can not read at all because of neck pain.

Concentration

- 0-I can concentrate fully when I want with no difficulty.
- 1-I can concentrate fully when I want with slight difficulty.
- 2-I have a fair degree of difficulty concentrating when I want.
- 3-I have a lot of difficulty concentrating when I want.
- 4-I have a great deal of difficulty concentrating when I want.
- 5-I cannot concentrate at all.

Work

- 0-I can do as much work as I want.
- 1-I can only do my usual work but no more.
- 2-I can only do most of my usual work but no more.
- 3-I can not do my usual work.
- 4-I can hardly do any work at all.
- 5-I can not do any work at all.

Personal Care

- 0-I can look after myself normally without causing extra pain.
- 1-I can look after myself normally but it causes extra pain.
- 2-It is painful to look after myself and I am slow and careful.
- 3-I need some help but I manage most of my personal care.
- 4-I need help every day in most aspects of self care.
- 5-I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- 0-I can lift heavy weights without extra pain.
- 1-I can lift heavy weights but it causes extra pain.
- 2-Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g., on a table)
- 3-Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- 4-I can only lift very light weights.
- 5-I can not lift or carry anything at all.

Driving

- 0-I can drive my car without any neck pain.
- 1-I can drive my car as long as I want with slight neck pain.
- 2-I can drive my car as long as I want with moderate neck pain.
- 3-I can not drive my car as long as I want because of moderate neck pain.
- 4-I can hardly drive at all because of severe neck pain.
- 5-I can not drive my car at all because of neck pain.

Recreation

- 0-I am able to engage in all my recreation activities without neck pain.
- 1-I am able to engage in all my usual recreation activities with some neck pain.
- 2-I am able to engage in most but not all my usual recreation activities because of neck pain
- 3-I am only able to engage in a few of my usual recreation activities because of neck pain.
- 4-I can hardly do any recreation activities because of neck pain.
- 5-I can not do any recreation activities at all.

Headaches

- 0-I have no headaches at all.
- 1-I have slight headaches which come infrequently.
- 2-I have moderate headaches which come infrequently.
- 3-I have moderate headaches which come frequently.
- 4-I have severe headaches which come frequently.
- 5-I have headaches almost all the time.

Neck
Score

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Pain Intensity

- 0-The pain comes and goes and is very mild.
- 1-The pain is mild and does not vary much.
- 2-The pain comes and goes and is moderate.
- 3-The pain is moderate and does not vary much.
- 4-The pain comes and goes and is very severe.
- 5-The pain is very severe and does not vary much.

Sleeping

- 0-I get no pain in bed.
- 1-I get pain in bed but it does not prevent me from sleeping well.
- 2-Because of pain my normal night's sleep is reduced by less than 25%.
- 3-Because of pain my normal night's sleep is reduced by less than 50%.
- 4-Because of pain my normal night's sleep is reduced by less than 75%.
- 5-Pain prevents me from sleeping at all.

Sitting

- 0-I can sit in any chair as long as I like.
- 1-I can only sit in my favorite chair as long as I like.
- 2-Pain prevents me from sitting more than 1 hour.
- 3-Pain prevents me from sitting more than 1/2 hour.
- 4-Pain prevents me from sitting more than 10 minutes.
- 5-I avoid sitting because it increases pain immediately.

Standing

- 0-I can stand as long as I want without pain.
- 1-I have some pain while standing but it does not increase with time.
- 2-I cannot stand for longer than 1 hour without increasing pain.
- 3-I cannot stand for longer than 1/2 hour without increasing pain.
- 4-I cannot stand for longer than 10 minutes without increasing pain.
- 5-I avoid standing because it increases pain immediately.

Walking

- 0-I have no pain while walking.
- 1-I have some pain while walking but it doesn't increase with distance.
- 2-I cannot walk more than one mile without increasing pain.
- 3-I cannot walk more than 1/2 mile without increasing pain.
- 4-I cannot walk more than 1/4 mile without increasing pain.
- 5-I cannot walk at all without increasing pain.

Personal Care

- 0-I do not have to change my way of washing or dressing in order to avoid pain.
- 1-I do not normally change my way of washing or dressing even though it causes some pain.
- 2-Washing and dressing increases the pain but I manage not to change my way of doing it.
- 3-Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- 4-Because of the pain I am unable to do some washing and dressing without help.
- 5-Because of the pain I am unable to do any washing and dressing without help.

Lifting

- 0-I can lift heavy weights without extra pain.
- 1-I can lift heavy weights but it causes extra pain.
- 2-Pain prevents me from lifting heavy weights off the floor.
- 3-Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g., on a table).
- 4-Pain prevents me from lifting heavy weights but I can manage light to medium weights.
- 5-I can only lift very light weights.

Traveling

- 0-I get no pain while traveling.
- 1-I get some pain while traveling but none of my usual forms of travel make it worse.
- 2-I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- 3-I get extra pain while traveling which causes me to seek alternate forms of travel.
- 4-Pain restricts all forms of travel except that done while lying down.
- 5-Pain restricts all forms of travel.

Social Life

- 0-My social life is normal and gives me no extra pain.
- 1-My social life is normal but increases the degree of pain.
- 2-Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.)
- 3-Pain has restricted my social life and I do not go out very often.
- 4-Pain has restricted my social life to my home.
- 5-I have hardly any social life because of the pain.

Changing degree of pain

- 0-My pain is rapidly getting better.
- 1-My pain fluctuates but overall is definitely getting better.
- 2-My pain seems to be getting better but improvement is slow.
- 3-My pain is neither getting better or worse.
- 4-My pain is gradually worsening.
- 5-My pain is rapidly worsening.

Back
Score

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