

MOTOR VEHICLE ACCIDENT QUESTIONNAIRE (4 PAGES NEED TO BE COMPLETED)

1. COMPLETE THIS PAGE
2. MOTOR VEHICLE ACCIDENT HISTORY
3. NECK PAIN DISABILITY QUESTIONNAIRE
4. LOW BACK PAIN DISABILITY QUESTIONNAIRE

Name: _____ Birth date: _____ Sex: F M
 First **Middle** **Last** **Month** **Day** **Year**

Address: _____ Postal Code: _____

Phone number: Home: _____ Cellular: _____ Work: _____

Please circle which telephone number you would prefer to be contacted at.

E-mail address: _____ Personal health #: _____

Employer: _____ Nature of Work: _____

Who may we thank for referring you to our office? _____

Informed Consent to Chiropractic Care

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are, or may be some risks associated with such treatment.

In particular you should note:

- a) While rare, some patients have experienced rib fractures or muscle and ligament strains or sprains following spinal adjustments.
- b) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment and on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustments is extremely remote.
- c) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment, although scientific study has never demonstrated such injuries are caused, or may be caused by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustments, have been the subject of government reports and multi-disciplinary studies conducted over many years, and has been demonstrated to be a highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular, (including spinal adjustments), as well as the content of this consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

Patient signature (Legal Guardian)

Witness of Signature

date

MOTOR VEHICLE ACCIDENT HISTORY

Adjuster name: _____ Phone number: _____ Claim number: _____

Today's date: |_____| |_____| |_____| Date of the accident: |_____| |_____| |_____| Time of the accident: _____
month day year month day year

Where was your vehicle impacted? Back of car Front of car Driver side Passenger side Roof
What was your position in the vehicle? Driver Front passenger Rear left passenger Rear right passenger
 Middle front Middle back Type of vehicle you were in: _____

Type(s) of vehicle(s) involved other than yours: _____
Prior to accident my vehicle was: Stopped Brakes applied Moving, (estimated speed of your vehicle): _____

Road conditions were: Dry Wet Snowy Icy Hands on steering wheel: Yes Other _____

Were you wearing a seatbelt? No Yes: Full shoulder and lap belt Lap belt only

Did air bags deploy? Yes No Headrest position: Behind head No headrest

Position of head at impact: Straight Turned left Turned right Looking up Looking down Can't recall

Position of body: Upright Turned left Turned right Other (describe) _____

Did any part of your body strike the inside of your car? No Yes (describe): _____

Did police attend the accident scene? Yes No Did ambulance attend? Yes No

Did you receive medical attention at the accident scene? Yes No

Describe your injuries from the accident: _____

Symptoms occurring since accident: Headaches Neck pain Shoulder pain Mid back pain Low back pain
 Chest pain Arm pain/Numbness Hand pain/numbness Leg pain/numbness Foot pain/numbness
 Stomach upset/digestive difficulties Diarrhea Constipation Fainting Blurred vision Ringing in ears
 Loss of balance Nausea Anxiety Tension Irritability Fatigue Emotional Stability Other (describe) _____

Did you go to the hospital after the accident? Yes No (If no, where did you go?) _____

If, yes how did you get there? Ambulance Drove self Someone drove me (name of hospital) _____

What treatment did you receive? (check those that apply)

Medication X-rays Splints Neck brace Cast Surgery Ice-pack Hot-pack Crutches

Identify medication given and any recommendations the hospital made for you? _____

Have you seen anyone else for your accident injuries? (doctor, physiotherapist, etc. If so, who?) _____

Nature of work: _____ (Please check those that apply to your job)

Do you work full time? Yes (# of hours per week) _____ No (# of hours per week) _____ Not working

Frequent bending Frequent lifting Prolonged sitting Prolonged standing Sitting at desk

Driving Computer use Arm use with arms elevated or extended Repetitive movements

Have you missed any time from work? Yes No If yes, give dates: _____

Please give a brief description of the nature of your work duties: _____

Do you drive or commute to your job? No Yes If yes, how long is your daily commute? _____

Before the accident was your lifestyle: Active Moderately active Inactive

Since the accident is your lifestyle: Active Moderately active Inactive

Check those activities you used to do **BEFORE** the accident, which have been affected since the accident:

House work Exercise Dance Sports Yard work Activities with children Sleep Standing

Sitting Driving Running Other (describe) _____

Did you ever experience similar symptoms prior to the accident? No Yes (describe) _____