Pamer Chiropractic Life Center East

Motor Vehicle Accident Questionnaire

Patient Name: _____ Date of Accident: _____
Patient's Auto Insurance: _____ Full Coverage or Liability (circle one)
Claim #: _____ Insurance Phone #: _____

Patient Location:

Check all that applies

What was your location in the vehicle? ☐ Driver ☐ Passenger

If passenger, what location? ☐ Front ☐ Middle ☐ Rear
☐ Left ☐ Middle ☐ Right

Your Vehicle Description:
Check all that applies

Type: ☐ Car ☐ Van ☐ Truck ☐ Bus ☐ SUV ☐ Motorcycle ☐Other_____

Size: ☐ Compact ☐ Mid Size ☐ Full Size

Action: ☐ Stopped ☐ Slowing ☐ Acceleration ☐ Cruising

Speed: _____MPH

Time of accident: ☐ Day light ☐ Dawn ☐ Dusk ☐ Dark

Road Condition: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice

Visibility: ☐ Good ☐ Fair ☐ Poor

Impact Information:
Check all that applies

What impacted your vehicle: ☐ Vehicle ☐ Object

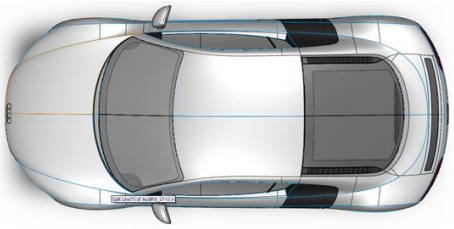
Object: _____

Vehicle Type: ☐ Car ☐ Van ☐ Truck ☐ Bus ☐ SUV ☐ Motorcycle ☐ Other: _____

Size: ☐ Compact ☐ Mid Size ☐ Full Size

Damage to your vehicle: ☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure

Impact Location: Circle all that apply:



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During Impact Information:
Check all that applies

Seat Belt Impact? ☐ Yes ☐ No Brakes Applied? ☐ Yes ☐ No

Air Bag Deployed? ☐ Yes ☐ No Seat Broken? ☐ Yes ☐ No

Prepare for Accident: ☐ Un-Expected ☐ Expected ☐ Expected and Braced

Head Rest Position: ☐ Low ☐ Mid ☐ High ☐ None

Body Position: ☐ Straight ☐ Rotated Left ☐ Rotated Right ☐ Unsure ☐ Other _____

Body Thrown: ☐ Yes ☐ No

Direction of Throw: ☐ Backwards ☐ Forward ☐ Outside ☐ Unsure ☐ Other _____

Head Position: ☐ Straight ☐ Rotated Left ☐ Rotated Right ☐ Forward ☐ Unsure

Head Motion: ☐ Forward Backwards ☐ Backwards Forward ☐ Right Left ☐ Left Right

☐ Unsure ☐ Other: _____

Body Impact:
During the Accident

☐ Left Hand ☐ Right Hand ☐ Upper Back ☐ Mid Back ☐ Lower Back

☐ Left Shoulder ☐ Right Shoulder ☐ Upper Torso ☐ Mid Torso ☐ Lower Torso

☐ Left Elbow ☐ Right Elbow ☐ Left Leg ☐ Right Leg ☐ Head

☐ Left Foot ☐ Right Foot ☐ Left Knee ☐ Right Knee

☐Left Arm ☐ Right Arm ☐ Other: _____

After Accident Information:
Immediately following Accident Symptoms:

☐ Dizzy/Dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented

☐ Unconscious ☐ Other: _____

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Medical Information:

Did you receive medical care? ☐ Yes ☐ No
If yes, please check off the following that apply:

Time of Accident: ☐ Next Day ☐ At time of Accident ☐ Later that Day ☐ Days Later: _____

Transportation: ☐ Drove Self ☐ Ambulance ☐ Other: _____

Went To: ☐ Chiropractor ☐ Family Dr. ☐ ER ☐ Urgent Care ☐ Other: _____

Admitted to Hospital: ☐ No ☐ Yes How many days spent in hospital: _____

Test: ☐ X-Ray ☐ Lab work ☐ MRI ☐ CT Scan ☐ Other: _____

Treatment: ☐ Ice Pack ☐ Hot Pack ☐ Cervical Collar ☐ Medication ☐ Other: _____

Previous Injuries

Previous Injuries/ Accidents: ☐ No ☐ Yes

Specify: _____

Residual pain from Previous Injury/ Accidents: ☐ No ☐ Yes

Specify: _____

Later Symptoms:

Head: ☐ Headache ☐ Dizziness ☐ Blurred Vision ☐ Light Headedness

☐ Loss of Vision ☐ Fainting ☐ Loss of Memory ☐ Pain in Ear

☐ Double Vision ☐Other: _____

Neck: ☐ Pain in Neck ☐ Tilt Forward ☐ Bend Left ☐ Turn Left

☐ Muscle Spasm ☐ Tilt Backward ☐ Bend Right ☐ Turn Right

☐ Popping in Neck ☐ Other: _____

Pamer Chiropractic Life Center East

Motor Vehicle Accident Questionnaire

Shoulders: ☐ Pain in Joint ☐ Tension in Shoulder ☐ Muscle Spasms

☐ Pain Across Shoulder ☐ Cant Raise Arms Above Shoulder Level

☐ Cant Raise Arms Over Head ☐ Other: _____

Arms and Hands: ☐ Pain in Fingers ☐ Hands Cold ☐ Loss of Grip Strength

☐ Pins and Needles in Hands ☐ Pins and Needles in Fingers

☐ Numbness in Left Arm ☐ Numbness in Right Arm

☐ Swollen Joints in Fingers ☐ Other: _____

Chest: ☐ Chest Pain ☐ Pain Around Ribs ☐ Shortness of Breath

☐ Breast Pain ☐ Other: _____

Abdomen: ☐ Nervous Stomach ☐ Nausea ☐ Diarrhea

☐ Gas ☐ Constipation ☐ Other: _____

Mid Back: ☐ Sharp Stabbing ☐ Mid Back Pain ☐ Pain from Font to Back

☐ Dull Ache ☐ Pain in Kidney Area ☐ Muscle Spasms

☐ Pain Between Shoulders ☐ Other: _____

Lower Back: ☐ Low Back Pain

Lower back pain is worse when:

☐ Working ☐ Sitting ☐ Lifting ☐ Bending

☐ Coughing ☐ Standing ☐ Laying Down ☐ Muscle Spasms

☐ Other: _____

Hips, Legs, & Feet: ☐ Pain and Needles in Legs ☐ Pain in Buttocks ☐ Pain down Leg

☐ Pain in Hip Joint ☐ Feet Feel Cold ☐ Swollen Feet

☐ Numbness in Toes ☐ Numbness of Leg ☐ Cramps in feet

☐ Knee Pain ☐ Leg Cramps ☐ Cramps in Feet

☐ Other: _____

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General: ☐ Nervous ☐ Fatigue ☐ Irritable ☐ Depressed ☐ Cramping

☐ Generally Feel Run Down ☐ Prostate Pain/Swelling

☐ Difficulty Urinating ☐ Night Urination ☐ Irregularity

☐ Loss of Sleep: _____ hrs per night

☐ Loss of Weight: _____ lbs

☐ Gain of Weight: _____ lbs

Other: _____

_____

_____

_____

Brief Description of Accident in your words:

_____

_____

_____

_____

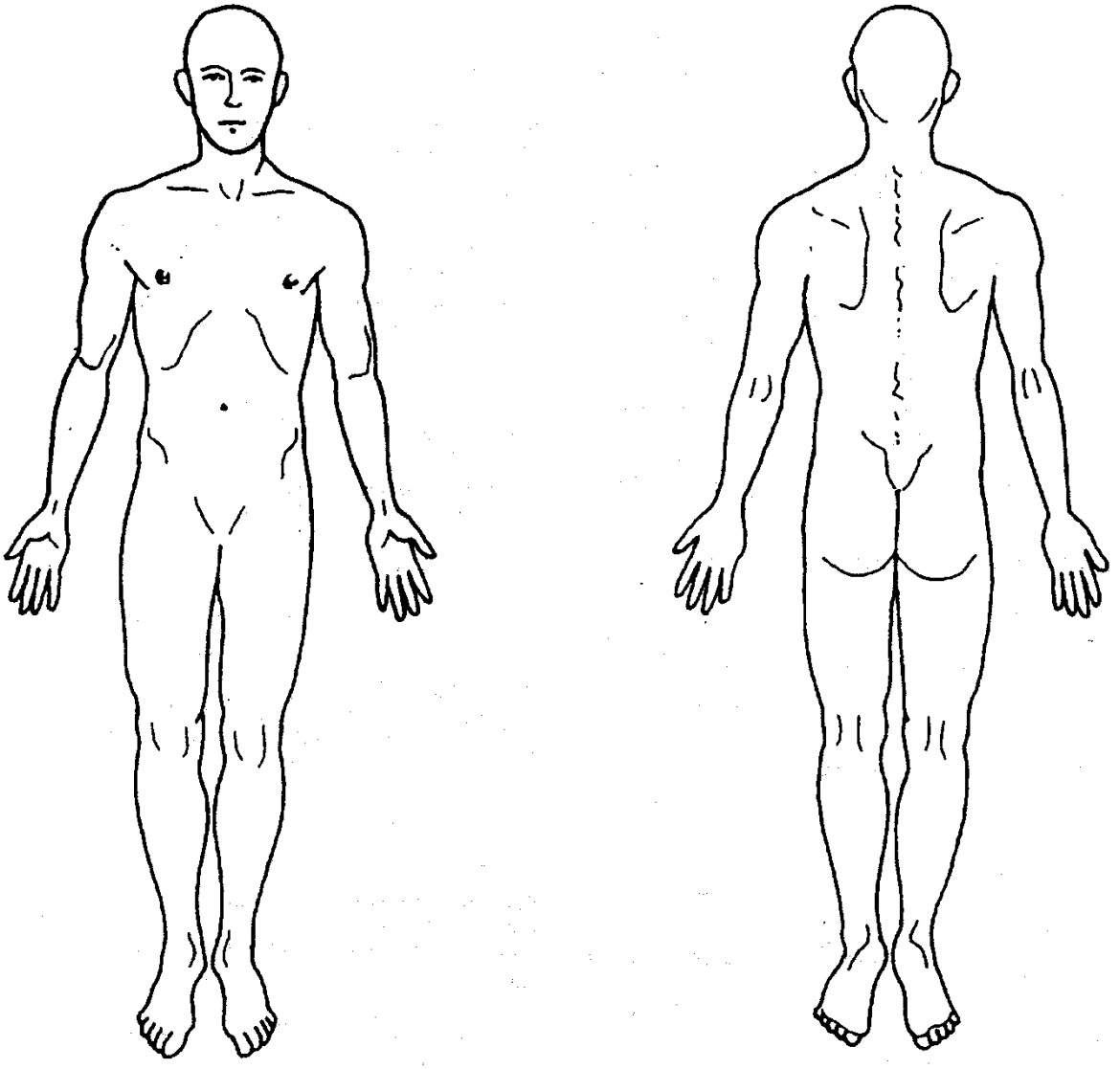
Patient's Signature: _____ Date: _____

Pamer Chiropractic Life Center East

Pain Diagram

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR PAIN OR DISCOMFORT RIGHT NOW

A=ACHE B=BURNING D=DULL N=NUMBNESS S=SHARP O=OTHER



Pamer Chiropractic Life Center East

Neck Disability Index

Name: _____ **Date:** _____

This questionnaire has been designed to give the doctor information as to how your NECK pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Personal Care (Washing, Dressing , ect.)

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

Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights, but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned, for example, on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can only lift very light weights at the most.
☐I cannot lift or carry anything at all

Reading

☐ I can read as much as I want to, with no pain in my neck.
☐ I can read as much as I want to, with slight pain in my neck.
☐ I can read as much as I want to, with moderate pain in my neck.
☐ I can't read as much as I want, because of the moderate pain in my neck.
☐ I can hardly read at all, because of the severe pain in my neck.
☐ I cannot read at all.

Headaches

☐ I have no headaches at all.
☐ I have slight headaches that come infrequently.
☐ I have moderate headaches that come infrequently.
☐ I have moderate headaches that come frequently.
☐ I have severe headaches that come frequently.
☐ I have headaches almost all the time.

Concentration

☐ I can concentrate fully when I want to, with no difficulty.
☐ I can concentrate fully when I want to, with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Work

☐ I can do as much work as I want to.
☐ I can do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

Driving

☐ I can drive my car without any neck pain.
☐ I can drive my car as long as I want, with slight pain in my neck.
☐ I can drive my car as long as I want, with moderate pain in my neck.
☐ I can't drive my car as long as I want, because of moderate pain in my neck.
☐ I can hardly drive at all, because of the severe pain in my neck.
☐ I can't drive my car at all.

Sleeping

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

Recreation

☐ I am able to engage in all my recreation activities, with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some neck pain.
☐ I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
☐ I am able to engage in few of my recreation activities, because of pain in my neck.
☐ I can hardly do any recreation activities, because of pain in my neck.
☐ I can't do any recreation activities at all.

Pamer Chiropractic Life Center East

Oswestry Low Back Disability Index

Name: _____ **Date: _____**

This questionnaire has been designed to give the doctor information as to how your LOWER BACK pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Pain Intensity

☐ The pain comes and goes and is very mild.
☐ The pain is mild and does not vary much.
☐ The pain comes and goes and is moderate.
☐ The pain is moderate and does not vary much.
☐ The pain comes and goes and is very severe.
☐ The pain is severe and does not vary much.

Personal Care

☐ I would not have to change my way of washing or dressing in order to avoid pain.
☐ I do not normally change my way or washing or dressing even though it causes some pain.
☐ Washing and dressing increases the pain, but I manage not to change my way of doing it.
☐ Washing and dressing increases the pain and I find it necessary to change my way or doing it.
☐ Because of the pain, I am unable to do some washing and dressing without help.
☐ Because of the pain, I am unable to do any washing and dressing without help.

Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights, but it causes extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
☐ Pain prevents me from lifting heavy weights off the floor.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can only lift very light weights at the most.

Walking

☐ I have no pain on walking.
☐ I have some pain on walking, but it does not increase with distance.
☐ I cannon walk more then one mile without increasing pain.
☐ I cannot walk more then ½ mile without increasing pain.
☐ I cannot walk more than ¼ mile without increasing pain.
☐ I cannot walk at all without increasing pain.

Sitting

☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than ½ hour.
☐ Pain prevents me from sitting more then 10 minutes.
☐ I avoid sitting because it increases pain right away.

Standing

☐ I can stand as long as I want without pain.
☐ I have some pain on standing, but it does not increase with time.
☐ I cannot stand for longer than one hour without increasing pain.
☐ I cannot stand for longer than ½ hour without increasing pain.
☐ I cannot stand for longer than 10 minutes without increasing pain.
☐ I avoid standing because it increases the pain right away.

Sleeping

☐ I get no pain in bed.
☐ I get pain in bed, but it does not prevent me from sleeping well.
☐ Because of pain, my normal night's sleep is reduced by less than ¼.
☐ Because of pain, my normal night's sleep is reduced by less than ½.
☐ Because of pain, my normal night's sleep is reduced by less than ¾.
☐ Pain prevents me from sleeping well.

Social Life

☐ My social life is normal and gives me no pain.
☐ My social life is normal, but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, ect.
☐ Pain has restricted my social life and I do not go out very often.
☐ Pain has restricted my social life to my home.
☐ I have hardly any social life because of the pain.

Traveling

☐ I get no pain while traveling.
☐ I get some pain while traveling, but none my usual forms of travel makes it any worse.
☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
☐ I get extra pain while traveling, which compels me to seek alternative forms of travel.
☐ Pain restricts all forms of travel.
☐ Pain prevents all forms of travel except that done lying down.

Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates, but is defiantly getting better.
☐ My pain seems to be getting better, but Improvement is slow at present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Pamer Chiropractic Life Center East

Doctor's Lien

I do hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered to me both by reason of the accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient's Signature: _____ Date: _____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above-named.

Attorney's Signature: _____ Date: _____

Please date, sign and return original copy to PAMER CHIROPRACTIC.

Pamer Chiropractic Life Center East
265 N McElroy Rd, Mansfield, OH 44905
Phone: 419-589-9898 Fax: 419-589-8186

Pamer Chiropractic Life Center East

Direct Assignment of Payment and Security Agreement for Medical Services

For good and valuable consideration, the undersigned directs you, my insurance company, third party payer and/or my attorney, to pay directly to *Pamer Chiropractic*, such sums as may be due and owing said office for services rendered to me, and to withhold such sums from any disability benefits, workers' compensation benefits or any other insurance benefits obligated to reimburse me, or from any settlement, judgment or verdict on my behalf as may be necessary to protect said office.

I hereby further give a lien to said office against any and all insurance benefits and proceeds of any settlement, judgment or verdict named herein, which may be paid to me as a result of injuries or illnesses for which I have been treated by said office. The undersigned does hereby assign and set over to said *Pamer Chiropractic* a sum of money equal to that amount which *Pamer Chiropractic* is entitled to payment for services rendered.

I understand that I remain personally responsible for the total amounts due to said office for their services, and I further understand and agree that this Assignment of Payment, Security Agreement for Medical Services, Lien, and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed by indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I hereby instruct and direct that check made out and mailed to:

Pamer Chiropractic Life Center East
265 N McElroy Rd
Mansfield, OH 44905

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and Pamer Chiropractic or me and mail directly to Pamer Chiropractic as follows:

(Patient's Name)_____
C/O Pamer Chiropractic
265 N McElroy Rd
Mansfield, OH 44905

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Name: _____ Signature: _____ Date: _____

Witness: **_____**