CROMWELL CHIROPRACTIC CENTER, LLC

28 SHUNPIKE ROAD, CROMWELL, CT 06416
860-635-4455 Phone 860-635-0499 Fax

Automobile Injury Intake Information

Name _____ Social Security Number _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address: _____

Birthdate _____ Age _____ Sex M F Marital Status M S W D # of Children _____

Occupation _____ Employer _____

Emergency Contact _____ Phone # _____ Relation _____

ACCIDENT INFORMATION:

Date of Accident: _____ Time of Accident _____

Did you report accident to the authorities? ☐ Police ☐ Employer

What was your position in the car? ☐ Driver ☐ Passenger

If passenger, where were you sitting? ☐ Front ☐ Left Rear ☐ Right Rear

Your vehicle: Year _____ Make _____ Model _____

Your estimated speed at the moment of accident? _____ miles per hour

Was your vehicle: ☐ Stopped ☐ Slowing ☐ Accelerating

Other Vehicle: Year _____ Make _____ Model _____

Other vehicle's speed at the moment of accident? _____ miles per hour

Did your vehicle strike another vehicle? ☐ Yes ☐ No

Did other vehicle strike your vehicle? ☐ Yes ☐ No

If yes, was the impact from: ☐ Front ☐ Right Rear ☐ Right Side ☐ Right Front ☐ Rear ☐ Left Rear ☐ Left Side ☐ Left Front

Describe the accident in your own words:

_____

_____

_____

Road Conditions: ☐ Dry ☐ Wet ☐ Snow ☐ Ice

Which direction was your head turned at impact? ☐ Left ☐ Right ☐ Facing Forward ☐ Up ☐ Down

At time of impact were both hands on steering wheel? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No If yes, ☐ Lap ☐ Shoulder

Does the car have headrests? ☐ Yes ☐ No if yes, were they ☐ Up ☐ Down

Did an airbag deploy? ☐ Yes ☐ No

Was the seat back broken? ☐ Yes ☐ No

Were you aware of the impending collision? ☐ Yes ☐ No

Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No

If yes specify: ☐ Steering Wheel ☐ Dashboard ☐ Windshield ☐ Side Door ☐ Arm Rests ☐ Side Window ☐ Roof
State part of body: ☐ Chest ☐ Chin ☐ Head ☐ Knee ☐ Hand ☐ Shoulder ☐ Other _____

Was your (or the driver's) foot on the brake? ☐ Yes ☐ No

Were you wearing glasses or a hat? ☐ Yes ☐ No If yes were they still on after impact? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No Dazed? ☐ Yes ☐ No

Did you go to the hospital? ☐ Yes ☐ No

If yes, when? ☐ At the time of the accident ☐ Next Day ☐ Other _____

How did you get to the hospital? ☐ Ambulance ☐ Private Transportation

Name of Hospital _____ Name of Doctor _____

Were you x-rayed at the hospital? ☐ Yes ☐ No If yes, what was the diagnosis? _____
What treatment was given? _____

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No

If yes, Doctor's Name _____ Phone # _____

PREVIOUS ACCIDENT HISTORY:

Have you ever been involved in any other motor vehicle accidents even if you were not driving? ☐ no ☐ yes

If yes, how many accidents? _____

Describe previous accident(s): _____

_____

HEALTH INFORMATION:

What is your main complaint? _____

How long have you had this condition? _____

What activities aggravate your condition? _____

What activities improve your condition? _____

What does it feel like? (sharp pain, burning, numbing and tingling) _____

Does this radiate to other areas? No Yes Where? _____

Rate your pain on a scale of 1 to 10: (1 = mild pain, 5 = moderate and 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

What percentage of the day does this condition bother you? 25% 50% 75% 100%

Do you have another complaint? No Yes (Please describe below)

_____

How long have you had this condition? _____

What activities aggravate your condition? _____

What activities improve your condition? _____

What does it feel like? (sharp pain, burning, numbing and tingling) _____

Does this radiate to other areas? No Yes Where? _____

Rate your pain on a scale of 1 to 10: (1 = mild pain, 5 = moderate and 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

What percentage of the day does this condition bother you? 25% 50% 75% 100%

List other complaints: _____

List any tests that were performed and dates: (MRI's, x-rays) _____

_____

_____

List the Doctors' Name who ordered the tests and where the test was performed (outpatient center, doctor office): _____

_____

List surgical operations, dates performed and what hospital: _____

_____

List current medications: _____

_____

FAMILY PHYSICIAN NAME (PCP): _____

GROUP NAME: _____ **PHONE #:** _____

Address: _____ City: _____

PERSONAL HEALTH HISTORY:

Cancer Heart Disease/Stroke Diabetes High Blood Pressure Rheumatoid Arthritis

Allergies? _____

Other (please describe) _____

FAMILY HEALTH HISTORY:

Cancer Heart Disease/Stroke Diabetes High Blood Pressure Rheumatoid Arthritis

Other (please describe) _____

HEALTH INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? Yes No

Do you currently have health insurance? Yes No

If yes, Name of Company _____

Identification # _____ Group # _____

Are you covered by Medicare? No Yes If yes, Identification # _____

Do you have secondary insurance? No Yes Insurance Company Name _____

YOUR AUTO INSURANCE INFORMATION:

Insurance Company Name: _____ Policy #: _____

Adjustor's Name: _____ Phone # _____ ext. _____

Claim #: _____

THIRD PARTY AUTO INSURANCE INFORMATION:

Name of the person who caused the accident: _____

Insurance Company Name: _____ Policy #: _____

Adjustor's Name: _____ Phone # _____ ext. _____

Claim #: _____

ATTORNEY INFORMATION:

Do you have an attorney representing you? No Yes If yes, Attorney Name _____

Address: _____ City _____ Zip Code _____

Phone #: _____

I understand that Cromwell Chiropractic Center, LLC will prepare any necessary reports and forms to assist me in making collections from my insurance company. I am requesting payment of government and health insurance benefits be made directly to Robert M. Shortell, D/B/A Cromwell Chiropractic Center, LLC who accepts assignment for services rendered. In addition, I authorize the release of any medical or other information necessary to process my claims. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian or Parent's Signature _____

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Loss of Enjoyment of Life

This form is to determine whether you have lost the ability to perform activities in certain areas of life that you have enjoyed doing prior to your injury or illness. This is not about what you can do even though it may be painful or cause you duress, this is about what you cannot do, that you use to able to enjoy doing with no problem. Please indicate if there are any areas like that for you and then sign and date this form at the bottom, so that is can be part of your medical records.

❑ Work Activities

❑ I have lost enjoyment and the ability to perform certain aspects of 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:

a. ❑ Full Time Employed
b. ❑ Part Time Employed
c. ❑ Casual Employee
d. ❑ Seasonal Employee
e. ❑ Not Employed

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

a. ❑ I Resumed My Same Job and Duties
b. ❑ I Resumed My Same Job with Lighter Duties
c. ❑ I Resumed Alternate Duties Within the Same Industry
d. ❑ I Changed Industry
e. ❑ I Have Not Resumed Work

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

a. ❑ I have lost status within the company.
b. ❑ I have lost job security.
c. ❑ I have lost promotional prospects.
d. ❑ I have difficulty in performing my normal job duties.
e. ❑ My quality of work is reduced since the collision.
f. ❑ I am unable to perform my pre-accident job

❑ Domestic Activities

❑ I have lost enjoyment and ability to perform some of my domestic activities as a result of the injuries caused in this collision.

Duties Under Duress Index

Have you **continued to do** any of the following activities despite the pain, discomfort or loss of function caused by your injuries? Please fill this in and then sign and date this form as a part of your injury records. This is geared toward any current injuries are how they may be affecting your functional ability to perform these activities.

❑ *Work*

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 am injured 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: _____

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

a. ❑ Mobility / Stability Problems
   i. ❑ Climbing
   ii. ❑ Kneeling
   iii. ❑ Lifting
   iv. ❑ Walking for Long Periods
b. ❑ Dexterity Problems
   i. ❑ Finger Movements
   ii. ❑ Wrist Movements
c. ❑ Problems with Fatigue
d. ❑ Postural Difficulties
   i. ❑ Bending
   ii. ❑ Sitting for Long Periods
   iii. ❑ Standing for Long Periods
   iv. ❑ Stooping
e. ❑ Problems with Anxiety / Depression
f. ❑ Problems with Vertigo or Spinning Sensations
   i. ❑ Dizziness
   ii. ❑ Giddiness
   iii. ❑ Sensation of Irregular Motion
   iv. ❑ Sensation of Whirling Motion
g. ❑ Problems with Tinnitus or Ringing in the Ears
h. ❑ Problems with Reduced Concentration
   i. ❑ Can't Concentrate
   ii. ❑ Can't Think Properly
   iii. ❑ Making Mistakes
i. ❑ Pain
   i. Where?_____

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Duties Under Duress

❑ Duration of Symptoms

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

❑ *Domestic Duties*

❑ I have experienced pain while performing the following activities *inside* my home, but have done them anyway:

a. ❑ Laundry
b. ❑ Dishwashing
c. ❑ Vacuuming
d. ❑ Washing Windows
e. ❑ Cleaning
f. ❑ Preparing Meals

❑ Due to my injuries, I have brought in the following assistance:

a. ❑ Paid Housekeeper
b. ❑ Unpaid Assistance
c. ❑ None

❑ My family status would best be described as:

a. ❑ Single
b. ❑ Single Parent at Home
c. ❑ Spouse Only
d. ❑ Spouse and Children at Home

❑ I have the following number of children:

a. ❑ 0
b. ❑ 1
c. ❑ 2
d. ❑ 3
e. ❑ 4
f. ❑ 5
g. ❑ ____

❑ The number of my children in the following age category is:
  a. ❑ Number of children 0 to 5 years: _____
  b. ❑ Number of children 5-11 years: _____
  c. ❑ Number of children older than 11:_____

❑ Domestic Assistance
  a. ❑ I do receive domestic assistance
  b. ❑ I do not receive domestic assistance

❑ Duration of Symptoms
  a. ❑ I experienced problems doing my normal domestic activities for _____ weeks.
  b. ❑ My doctors have instructed me that my inability to perform my normal pre-accident domestic activities without pain is a permanent condition.
  c. ❑ My problems in performing my normal domestic activities is ongoing, but my doctors have not instructed me that the conditions is permanent.

❑ *Household*

❑ I have experienced problems with the following activities *outside* my home:
  a. ❑ Painting the Outside of the House
  b. ❑ Landscaping
  c. ❑ Mowing the Grass
  d. ❑ Trimming the Bushes / Trees
  e. ❑ Washing Windows
  f. ❑ Gardening
  g. ❑ Taking Out the Trash
  h. ❑ Washing the Cars
  i. ❑ Maintaining the Cars
  j. ❑ Maintaining Yard Equipment
  k. ❑ Doing Other External House Work; Specify: _____

❑ Duration of Symptoms
  a. ❑ I experienced problems doing my normal household activities for _____ weeks.
  b. ❑ My doctors have instructed me that my inability to perform my normal pre-accident household activities without pain is a permanent condition.
  c. ❑ My problems in performing my normal household activities is ongoing, but my doctors have not instructed me that the conditions is permanent.

❑ *Studies / Educational Duties*

❑ As a student I have experienced problems with one of the following activities since the collision:
  a. ❑ Carrying Books
  b. ❑ Sitting in Classes
  c. ❑ Looking Down to Read Textbooks
  d. ❑ Other: _____

❑ I have also experienced the following changes in my ability to perform at school as a result of injuries sustained in this collision:

a. ❑ Mobility / Stability Problems
   i. ❑ Climbing
   ii. ❑ Kneeling
   iii. ❑ Lifting
   iv. ❑ Walking for Long Periods
b. ❑ Dexterity Problems
   i. ❑ Finger Movements
   ii. ❑ Wrist Movements
c. ❑ Problems with Fatigue
d. ❑ Postural Difficulties
   i. ❑ Bending
   ii. ❑ Sitting for Long Periods
   iii. ❑ Standing for Long Periods
   iv. ❑ Stooping
e. ❑ Problems with Anxiety / Depression
f. ❑ Problems with Vertigo or Spinning Sensations
   i. ❑ Dizziness
   ii. ❑ Giddiness
   iii. ❑ Sensation of Irregular Motion
   iv. ❑ Sensation of Whirling Motion
g. ❑ Problems with Tinnitus or Ringing in the Ears
h. ❑ Problems with Reduced Concentration
   i. ❑ Can't Concentrate
   ii. ❑ Can't Think Properly
   iii. ❑ Making Mistakes
i. ❑ Pain: Where?_____

At the time of this collision, my education would best be described as:

a. ❑ High School
b. ❑ Apprenticeship Studies
c. ❑ Technical College
d. ❑ University
e. ❑ Correspondence Course

My attendance before the collision is best described as:

a. ❑ Full Time
b. ❑ Part Time

d. ❑ Seasonal

After this Collision, I altered this travel in the following way:

a. ❑ I cancelled the travel plans
b. ❑ I didn't make the normal travel plans
c. ❑ I altered the travel plans due to the injury
d. ❑ I went, but with an increased level of pain
e. ❑ I went, but was impaired in my activities
f. ❑ I went and had minimal trouble
g. ❑ I went and had no trouble

❑ I have been unable to engage in any car travel since my collision, due to my injuries.
❑ I have been unable to engage in any plane travel since my collision, due to my injuries.
❑ I have been unable to engage in any train travel since my collision, due to my injuries.
❑ I have been unable to engage in any boat travel since my collision, due to my injuries.

Please List any other activity that you are no longer able to do because of your injuries:_____
_____
_____
_____
_____

Patient Name Printed:_____ Date:_____

All of the above truly reflects what I am not able to do since the onset of my injuries/condition.

Patient Signature;_____

Page 43, Appendix 3-1 Pain Disability Questionnaire
Page 600, Figure 17-A Pain Disability Questionnaire (PDQ)

Patient Name: _____ **Date:** _____

Instructions: These questions ask for your views about how your 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 sit / stand 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 / 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 your 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 doctors much more often than before your 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 the 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, and / or work activities?
No problems — *Severe problems*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

_____
Examiner

Anagnostis C, Gatchel RJ, Mayer TG. The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. Spine 2004; 29 (20): 2290-2302.