445 South Blackstock Road Suite A
Spartanburg, SC 29301
Phone: (864) 804-6395
www.sesportschiro.com
Tyler Jack, DC, FMT, SFMA, FAKTR

Motor Vehicle Collision Intake Form

Patient Name: ____ **Date:** ___________

Address______________________________City_______________ State _________ Zip Code ____________

Home Phone __________________________Work Phone_______________ Cell Phone _____________________

Date of Birth_____________ Age__________ Social Security #________________________________

Email Address: ______________________________
What sex were you assigned at birth on your original birth certificate? Male Female Choose not to disclose
Marital Status: Married Single Divorced Widowed
Occupation____
Employer____

Have you ever received Chiropractic Care? Yes No If yes, when? _______________________________
Name of most recent Chiropractor: ____

1. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**
____
____
____

2. **Since the Motor Vehicle Collision, have you experienced any of the following:**
   A. Loss of Range of Motion: yes/no
      a. What body parts: ____
   B. Visual Disturbance : yes/no □ blurring l/r □ floaters l/r □ vision loss l/r □ hypersensitivity l/r
      % of time: ___ % of time: ___ % of time: ___ % of time: ___

   C. Dizziness: yes/no % of time: ____
   D. Anxiety: yes/no % of time: ____
   E. Depression: yes/no % of time: ____
   F. Difficulty Sleeping: yes/no

3. **Past Health History:**

   A. **Please indicate if you have a history of any of the following:**
   □ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
   □ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
   □ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's
   □ **None of the above** □ Other __________

   B. **Previous Injury or Trauma: (i.e.: motor vehicle accidents, falls)**
   ____

   Have you ever broken any bones? Which and when?
   ____

   C. **Allergies:** ____

Patient Name: ____ **Date:** __________

D. Medications: (Please list ALL prescription medications, nutritional supplements you are currently taking):

Medication/Supplement	Year Began	Dose	Frequency	Reason for Taking

Are you taking these medications according to prescribed instructions? □ Yes □ No
Have you had prolonged or regular use of NSAID's (Advil, Aleve, etc.) Motrin, Aspirin? □ Yes □ No
Have you had prolonged or regular use of Tylenol? □ Yes □ No

E. Surgeries:

Date	Type	Hospital/Surgeon	Complications

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome

____

____

____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _______________ □ **None of the above**

Deaths in immediate family: ____

Cause of parents or siblings death Age at death

____

____

____

5. Social and Occupational History:

A. Job description:

____

B. Work schedule:

____

C. Recreational activities (exercise routine/type, hobbies, etc. and how often):

____

D. Lifestyle:

Alcohol use? □ Yes □ No, If yes □ Daily □ Weekly □ Occasionally □ How much?_________ Type?______________
Tobacco use? □ Yes □ No, If yes □ Daily □ Weekly □ Occasionally □ How much?_________ Type?______________
Diet: How many meals do you eat per day? __________ How many times do you snack per day? ___________
Do you drink caffeinated beverages? ___________ if yes how many per day?_______
How many cups of water do you drink daily? ____________________
Sleep: How many hours per night? _______________
How many times do you wake up per night? ______ Are you able to fall back to sleep? □ Yes □ No

Patient Name: ____ **Date:** ___________

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other ___________ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other __________
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other ______________ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _______________ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____________________ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other ________ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other ______________ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _________ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____________________ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other ___________ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? ________________________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Southeast Sports Chiropractic, LLC/ Tyler Jack, DC** for services performed.

Patient or Guardian Signature ____
Date______________________

Patient Name: ____ **Date:** __________

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

______________________________ ______________________

Signature of Patient or Guardian Date

____

Printed Name

OFFICE POLICY/FINANCIAL AGREEMENT

We are honored that you have chosen us for your healthcare needs and we are committed to the successful treatment of your condition. This will require a comprehensive diagnostic exam on your first visit and a treatment plan that will include physiotherapy. Additionally, today's health care system requires that we reach a clear understanding to meet your needs effectively and prevent confusion.

- We will verify your benefits, file and track your insurance payments as contracted.
- You are responsible for the full payment of any fees the insurance company will not cover or remain as a result of incorrect verification information received by our office.
- Appointments are scheduled to give optimal time and individual attention.
  If you need to reschedule an appointment, **please give a 24-hour notice**.
  If you do not, you will impact other patients' ability to be seen during that time and **will be charged a $25 missed appointment fee.**
- Patients that develop a pattern of **missed appointments** or **failure to follow treatment plans** are released from care and referred to another provider who may be better suited to fit the patient's schedule and needs.

INSURANCE/THIRD-PARTY COVERAGE

We will supply you with information regarding deductibles, co-payments, covered charges, secondary insurance and usual and customary charges, but keep in mind that all insurance carriers have a disclaimer that states "the stated benefits are not a guarantee of payment." We accept and file group health insurance, Workers Compensation, managed care plans, Medicare and Automobile Liability Insurance. However, services rendered are the ultimate responsibility of the patient receiving care.

FLEX CARDS/HSA CARDS

It is possible to pay for co-pays, coinsurance, supplies or nutritional supplements with your insurance flex or HAS cards. However, if they deny these charges, it will be your responsibility to reimburse the administrator of this card, not the responsibility of Southeast Sports & Rehabilitation.

OTHER FORMS OF PAYMENT

Patients that do not have insurance or third-party coverage are responsible for full payment at the time of service. We accept cash, personal checks, most major credit cards and Care Credit. If you require special financial arrangements for your care, please ask we never want finances to be a barrier to you receiving the care you need.

INSURANCE AND CHIROPRACTIC

Most of us are used to using our health insurance each and every time we got to the doctor, when it comes to chiropractic, this works a little differently.
Insurance carriers will only cover chiropractic services that are related to an "active complaint". This can be due to an accident, injury or fall or simply one of those "I don't know what I did but I hurt" type of situations.
Insurance companies **DO NOT COVER** care that fail to meet medical necessity. Medical necessity is care that is deemed appropriate for conditions and that those conditions should improve with care over a period of treatment. In order to track your care we may need to see you on a regular basis for a period of time. Treatment plans need to be in place to justify medical necessity.

My signature below indicates that I have read and understood the Southeast Sports & Rehabilitation Office/Financial Policy:

____ __________________________

Patient or Guardian Signature Date

____ __________________________

Office Staff Witness Date

Southeast Sports & Rehabilitation **Motor Vehicle Collision Questionnaire** **Dr. Tyler Jack**

Patient Name: ______________________________ **Date:** ________

Date of Accident ____/_____/_____
Number of people in vehicle __________
Claim Number ________________________
Name of Adjustor/Attorney______________________________
Adjustor/Attorney Phone #______________________ FAX#:______________________

Name of the Street______________________________
Name of the Driver: ______________________________
Insurance Company______________________________

After the accident it was determined: ☐ I was at-fault
☐ Driver of another vehicle was at-fault
☐ Driver of the vehicle I was in was at-fault

Patient was located: ☐ Driver ☐Passenger- middle front ☐ Passenger- right front
☐ Passenger- Left rear ☐Passenger- middle rear ☐ Passenger -right rear

Patient Vehicle Type: ☐Compact ☐Mid-size ☐Full-Size ☐ SUV ☐Pick-up ☐Motorcycle
Second Vehicle Type: ☐Compact ☐Mid-size ☐Full-Size ☐ SUV ☐Pick-up ☐Motorcycle
Third Vehicle Type: ☐Compact ☐Mid-size ☐Full-Size ☐ SUV ☐Pick-up ☐Motorcycle

Road Conditions: ☐ Clear ☐ Dark ☐Dry ☐ Foggy ☐ Wet ☐Icy ☐ Snow Other: ______________________
Road Type: ☐ Asphalt ☐ Concrete ☐ Dirt ☐Gravel

Were you aware the accident was going to occur? ☐ Yes ☐ No
Were you wearing a seatbelt? ☐ Yes ☐ No
Did your airbag deploy? ☐ Yes ☐ No
Does your car have a head rest? ☐ Yes ☐ No
What position was the head rest in? ☐ Up ☐ Middle ☐ Down
Patient's Head Position: ☐ Looking Straight Ahead ☐ Left Level ☐ Left Up ☐ Left Down

Accident Details
Was your car braking? ☐ Yes ☐ No Was your car moving? ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Was the second vehicle braking? ☐ Yes ☐ No Was the second vehicle moving? ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Was the third vehicle braking? ☐ Yes ☐ No Was the third vehicle moving? ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Collision Details
First Impact: ☐ hit by other vehicle ☐ hit other vehicle ☐ hit by object ☐ hit object
Impact Location: ☐ front ☐ front-right ☐ front-left ☐ left ☐ right ☐ right-rear ☐ left-rear ☐ rear ☐ top
Second Impact: ☐ hit by other vehicle ☐ hit other vehicle ☐ hit by object ☐ hit object
Impact Location: ☐ front ☐ front-right ☐ front-left ☐ left ☐ right ☐ right-rear ☐ left-rear ☐ rear ☐ top
What specific injuries did you sustain due to the motor vehicle collision?
____
____

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Southeast Sports & Rehabilitation **Motor Vehicle Collision Questionnaire** **Dr. Tyler Jack**

Patient Name: ____ **Date:** __________

Collision Results

Body was thrown: ☐ Forward ☐ Backward ☐ Left ☐ Right ☐ Can't Remember
Did your hit your head? ☐ Yes ☐ No, **If yes** what did your head hit?
☐ airbag ☐ front windshield ☐ rearview mirror ☐ steering wheel ☐ dashboard
☐ back of the front seat ☐ side window/door ☐ another person's body ☐ headrest
Did you hit your Chest? ☐ Yes ☐ No, **If yes** what did your chest hit?
☐ airbag ☐ steering wheel ☐ dashboard ☐ back of the front seat ☐ side window/door
☐ another person's body ☐ shoulder harness
Did you hit your Shoulder? ☐ Yes ☐ No, **If yes** what did your shoulder hit?
☐ airbag ☐ steering wheel ☐ dashboard ☐ back of the front seat ☐ side window/door
☐ another person's body ☐ shoulder harness
Did you hit your Knee? ☐ Yes ☐ No, **If yes** what did your knee hit?
☐ airbag ☐ steering wheel ☐ dashboard ☐ back of the front seat ☐ side window/door
☐ another person's body ☐ shoulder harness
Did you hit your Hip? ☐ Yes ☐ No, **If yes** what did your hip hit?
☐ airbag ☐ steering wheel ☐ dashboard ☐ back of the front seat ☐ side window/door
☐ another person's body ☐ shoulder harness

Vehicle Damage

Patient Vehicle: ☐ totaled ☐ significant damage ☐ light damage ☐ no damage
Second Vehicle: ☐ totaled ☐ significant damage ☐ light damage ☐ no damage
Third Vehicle: ☐ totaled ☐ significant damage ☐ light damage ☐ no damage

Hospitalization/Other treatment for Injuries due to Motor Vehicle Collision

Were you hospitalized? ☐ Yes ☐ No, If yes for how many days/weeks?____ _________
When did you go to the hospital? ☐ immediately ☐ later same day ☐ next day ☐ date _______________
How were you transported to the hospital? ☐ ambulance ☐ life flight ☐ private transportation
What did the hospital recommend? ☐ no instructions ☐ Chiropractic ☐ orthopedist ☐neurologist ☐primary care
☐ other: ________________________________
Have you seen any other providers for injuries? ☐ Yes ☐ No
IF YES who? ☐ Chiropractor ☐ Orthopedist ☐Neurologist ☐ Primary care ☐ Physical Therapy ☐ Nurse practitioner ☐ Physician Assistant
What is the name of the practice or Urgent Care? ____
Did you have any images taken? ☐ Yes ☐ No, If yes what was taken: ☐X-ray ☐MRI ☐CT ☐Other _____________
What areas of the body had image? ____
What medications were you given and what is it for?
____
____
Is there any other information about the accident or your injuries we should know?
____
____

__________________________________ __________________________
Signature of Patient or Guardian Date

____
Printed Name

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Patient Name: ____ **Date:** ___________

NEW PATIENT HISTORY FORM

Please START at the TOP OF YOUR BODY and work your way down

Each symptom needs to be described individually (i.e. Headache, Neck pain, low back pain, etc.)

Symptom ___________________________________

- On a scale from 1-10, with 10 being the worst**, please circle the number that best describes the symptom most of the time:** 1 2 3 4 5 6 7 8 9 10
- What **percentage of the time you are awake** do you experience the above symptom at the above intensity:
  10 20 30 40 50 60 70 80 90 100
- Date symptoms began? ____
- **Was this symptom a result of a motor vehicle collision?** Yes No (circle one)
- **Did you have this symptom before this motor vehicle collision?** Yes No
  If so, what was the intensity (1-10 w/10 the worst) and frequency? _____/____% of time awake

- What makes the symptom **worse?** (**circle all that apply**):

Sitting	Sneezing	Looking Down	Typing
Standing	Coughing	Movement	House Chores
Walking	Straining	Rest	Exercise
Bending	Reaching	Lying supine	Stair Stepping
Lifting	Twisting	Lying prone	
Sleeping	Looking Up	Driving	

  Other (please describe in detail): ____

- What makes the symptom **better?** (**circle all that apply**):

Sitting	Support	Topical	Rest
Standing	Movement	Analgesic	Stretching
Lying	Heat	Ibuprofen	Exercise
Knees Bent	Ice	Medication	Adjustments

  Other (please describe in detail): ____

- Describe the **quality** of the symptom (**circle all that apply**):

Dull	Throbbing	Stabbing	Tingling
Aching	Burning	Cramping	Radiating
Sharp	Deep	Numbness	Stiffness

  Other (please describe in detail): ____
- Does the symptom **radiate** to another part of your body (circle one): yes no
  If yes, **where does the symptom radiate**?
  - Head: ____
  - Right/Left/Both: Shoulder, Upper Arm, Forearm, Arm to Hand, Fingers (specific)__________________
  - Right/Left/Both: Buttock, Thigh, Leg, Leg below Knee, Leg to foot, Toes (specific)_________________

  Other (describe in detail) ____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Anything else you can tell us about this symptom? ____
  ____

Patient Name: ____ **Date:** ___________

Symptom ___________________________________

- On a scale from 1-10, with 10 being the worst**, please circle the number that best describes the symptom most of the time:** 1 2 3 4 5 6 7 8 9 10
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Walking	Straining	Rest	Exercise
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Lifting	Twisting	Lying prone	
Sleeping	Looking Up	Driving	

  Other (please describe in detail): ____

- What makes the symptom **better?** (**circle all that apply**):

Sitting	Support	Topical	Rest
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Lying	Heat	Ibuprofen	Exercise
Knees Bent	Ice	Medication	Adjustments

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  - Morning Afternoon Evening Night Unaffected by time of day
- Anything else you can tell us about this symptom? ______________________________________
  ____

Patient Name: ____ **Date:** ___________

Symptom ____________________________________

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Walking	Straining	Rest	Exercise
Bending	Reaching	Lying supine	Stair Stepping
Lifting	Twisting	Lying prone	
Sleeping	Looking Up	Driving	

  Other (please describe in detail): ____

- What makes the symptom **better?** (**circle all that apply**):

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Standing	Movement	Analgesic	Stretching
Lying	Heat	Ibuprofen	Exercise
Knees Bent	Ice	Medication	Adjustments

  Other (please describe in detail): ____

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Dull	Throbbing	Stabbing	Tingling
Aching	Burning	Cramping	Radiating
Sharp	Deep	Numbness	Stiffness

  Other (please describe in detail): ____
- Does the symptom **radiate** to another part of your body (circle one): yes no
  If yes, **where does the symptom radiate**?
  - Head: ____
  - Right/Left/Both: Shoulder, Upper Arm, Forearm, Arm to Hand, Fingers (specific)____________________
  - Right/Left/Both: Buttock, Thigh, Leg, Leg below Knee, Leg to foot, Toes (specific)__________________
    Other (describe in detail) ____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Anything else you can tell us about this symptom? ____
  ____

Patient Name: ____ **Date:** __________

Symptom ___________________________________

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Walking	Straining	Rest	Exercise
Bending	Reaching	Lying supine	Stair Stepping
Lifting	Twisting	Lying prone	
Sleeping	Looking Up	Driving	

  Other (please describe in detail): ____

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Sitting	Support	Topical	Rest
Standing	Movement	Analgesic	Stretching
Lying	Heat	Ibuprofen	Exercise
Knees Bent	Ice	Medication	Adjustments

  Other (please describe in detail): ____

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Aching	Burning	Cramping	Radiating
Sharp	Deep	Numbness	Stiffness

  Other (please describe in detail): ____
- Does the symptom **radiate** to another part of your body (circle one): yes no
  If yes, **where does the symptom radiate**?
  - Head: ____
  - Right/Left/Both: Shoulder, Upper Arm, Forearm, Arm to Hand, Fingers (specific)___________________
  - Right/Left/Both: Buttock, Thigh, Leg, Leg below Knee, Leg to foot, Toes (specific)_________________
    Other (describe in detail) ____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Anything else you can tell us about this symptom? ____
  ____

Patient Name: ____ **Date:** ___________

Symptom ____________________________________

- On a scale from 1-10, with 10 being the worst**, please circle the number that best describes the symptom most of the time:** 1 2 3 4 5 6 7 8 9 10
- What **percentage of the time you are awake** do you experience the above symptom at the above intensity: 10 20 30 40 50 60 70 80 90 100
- Date symptoms began? ____
- **Was this symptom a result of a motor vehicle collision?** Yes No (circle one)
- **Did you have this symptom before this motor vehicle collision?** Yes No
  If so, what was the intensity (1-10 w/10 the worst) and frequency? _____/____% of time awake
- What makes the symptom **worse?** (**circle all that apply**):

Sitting	Sneezing	Looking Down	Typing
Standing	Coughing	Movement	House Chores
Walking	Straining	Rest	Exercise
Bending	Reaching	Lying supine	Stair Stepping
Lifting	Twisting	Lying prone	
Sleeping	Looking Up	Driving	

  Other (please describe in detail): ____

- What makes the symptom **better?** (**circle all that apply**):

Sitting	Support	Topical	Rest
Standing	Movement	Analgesic	Stretching
Lying	Heat	Ibuprofen	Exercise
Knees Bent	Ice	Medication	Adjustments

  Other (please describe in detail): ____

- Describe the **quality** of the symptom (**circle all that apply**):

Dull	Throbbing	Stabbing	Tingling
Aching	Burning	Cramping	Radiating
Sharp	Deep	Numbness	Stiffness

  Other (please describe in detail): ____

- Does the symptom **radiate** to another part of your body (circle one): yes no
  If yes, **where does the symptom radiate**?
  - Head: ____
  - Right/Left/Both: Shoulder, Upper Arm, Forearm, Arm to Hand, Fingers (specific)____________________
  - Right/Left/Both: Buttock, Thigh, Leg, Leg below Knee, Leg to foot, Toes (specific)__________________
    Other (describe in detail) ____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Anything else you can tell us about this symptom? ____
  ____

445 South Blackstock Road SuiteA **Spartanburg, SC 29301**
Phone: (864) 804-6395 **Fax: (864) 551-2985**
www.sesportschiro.com

Patient Name: ____ **Date:** ___________

Symptom ___________________________________

- On a scale from 1-10, with 10 being the worst**, please circle the number that best describes the symptom most of the time:** 1 2 3 4 5 6 7 8 9 10
- What **percentage of the time you are awake** do you experience the above symptom at the above intensity:
  10 20 30 40 50 60 70 80 90 100
- Date symptoms began? ____
- **Was this symptom a result of a motor vehicle collision?** Yes No (circle one)
- **Did you have this symptom before this motor vehicle collision?** Yes No
  If so, what was the intensity (1-10 w/10 the worst) and frequency? _____/____% of time awake

- What makes the symptom **worse?** (**circle all that apply**):

Sitting	Sneezing	Looking Down	Typing
Standing	Coughing	Movement	House Chores
Walking	Straining	Rest	Exercise
Bending	Reaching	Lying supine	Stair Stepping
Lifting	Twisting	Lying prone	
Sleeping	Looking Up	Driving	

  Other (please describe in detail): ____

- What makes the symptom **better?** (**circle all that apply**):

Sitting	Support	Topical	Rest
Standing	Movement	Analgesic	Stretching
Lying	Heat	Ibuprofen	Exercise
Knees Bent	Ice	Medication	Adjustments

  Other (please describe in detail): ____

- Describe the **quality** of the symptom (**circle all that apply**):

Dull	Throbbing	Stabbing	Tingling
Aching	Burning	Cramping	Radiating
Sharp	Deep	Numbness	Stiffness

  Other (please describe in detail): ____
- Does the symptom **radiate** to another part of your body (circle one): yes no
  If yes, **where does the symptom radiate**?
  - Head: ____
  - Right/Left/Both: Shoulder, Upper Arm, Forearm, Arm to Hand, Fingers (specific)____________________
  - Right/Left/Both: Buttock, Thigh, Leg, Leg below Knee, Leg to foot, Toes (specific)__________________
    Other (describe in detail) ____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Anything else you can tell us about this symptom? ____
  ____

Southeast Sports & Rehabilitation **Motor Vehicle Collision Questionnaire** **Dr. Tyler Jack**

Patient Name: ____ **Date:** ___________

Symptom ___________________________________

- On a scale from 1-10, with 10 being the worst**, please circle the number that best describes the symptom most of the time:** 1 2 3 4 5 6 7 8 9 10
- What **percentage of the time you are awake** do you experience the above symptom at the above intensity:
  10 20 30 40 50 60 70 80 90 100
- Date symptoms began? ____
- **Was this symptom a result of a motor vehicle collision?** Yes No (circle one)
- **Did you have this symptom before this motor vehicle collision?** Yes No
  If so, what was the intensity (1-10 w/10 the worst) and frequency? _____/____% of time awake

- What makes the symptom **worse?** (**circle all that apply**):

Sitting	Sneezing	Looking Down	Typing
Standing	Coughing	Movement	House Chores
Walking	Straining	Rest	Exercise
Bending	Reaching	Lying supine	Stair Stepping
Lifting	Twisting	Lying prone	
Sleeping	Looking Up	Driving	

Other (please describe in detail): ____

- What makes the symptom **better?** (**circle all that apply**):

Sitting	Support	Topical	Rest
Standing	Movement	Analgesic	Stretching
Lying	Heat	Ibuprofen	Exercise
Knees Bent	Ice	Medication	Adjustments

Other (please describe in detail): ____

- Describe the **quality** of the symptom (**circle all that apply**):

Dull	Throbbing	Stabbing	Tingling
Aching	Burning	Cramping	Radiating
Sharp	Deep	Numbness	Stiffness

Other (please describe in detail): ____

- Does the symptom **radiate** to another part of your body (circle one): yes no
  If yes, **where does the symptom radiate**?
  - Head: ____
  - Right/Left/Both: Shoulder, Upper Arm, Forearm, Arm to Hand, Fingers (specific)____________________
  - Right/Left/Both: Buttock, Thigh, Leg, Leg below Knee, Leg to foot, Toes (specific)__________________
    Other (describe in detail) ____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Anything else you can tell us about this symptom? ____
  ____