DISCOVER CHIROPRACTIC

HANS FREERICKS CHIROPRACTIC CORPORATION
www.mydiscoverchiropractic.com

Automobile Accident Questionnaire

Please answer all questions completely.

Name _____Gender _____ Date of Birth _____

Please explain in detail how your accident happened: _____

_____

_____

_____

Your Insurance Co. _____ Policy # _____ Claim # _____

Your Auto Make/Model/Year _____ Type of Damage to auto _____

Name of driver of other vehicle (if any) _____

Other Driver Insurance Co. _____ Policy # _____ Claim # _____

Other Driver Auto Make/Model/Year _____

Have you retained an attorney? _____ No _____ Yes If yes, who? _____

You were the: ☐ Driver *OR* ☐ Passenger in the: ☐ Front Seat ☐ Back Seat ☐ Using Seat Belts

Location of accident _____ Time and Date of accident _____

Were you knocked unconscious? _____ No _____ Yes If yes, for how long? _____

Was any other doctor consulted after your accident? ____ No ____ Yes If yes, who? _____

What was the diagnosis? _____

What treatment was given? _____

Since this accident, are your symptoms: ☐ Improving? ☐ Getting worse? ☐ Staying the same?

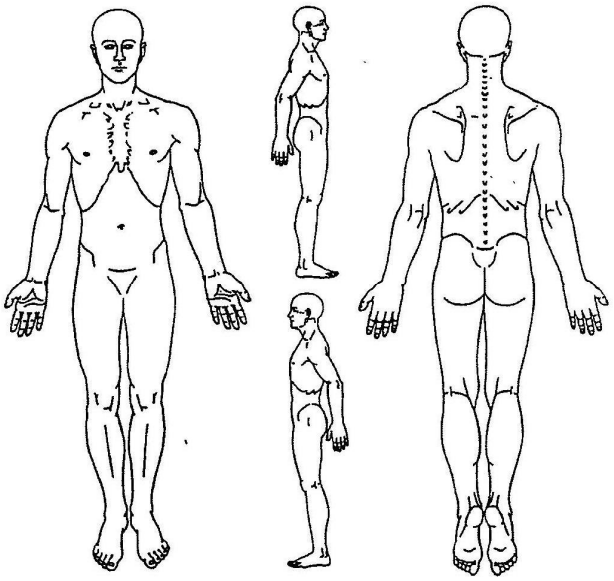
Health Questionnaire

Please rate each of the following using
a 0 - 10 pain/discomfort scale:
Example: 0 = no pain; 10 = worst pain imaginable

___ Neck Pain
___ Middle Back Pain
___ Low Back Pain
___ Shoulder Pain
___ Arm pain/numb/tingling
___ Leg pain/numb/tingling
___ Difficulty Sleeping
___ Fatigue

___ Headaches
___ Dizziness
___ Nausea
___ Shoulder Pain
___ Weakness
___ Other: _____
___ Other: _____
___ Other: _____

Please mark your areas of pain on the figure below



General Pain Disability Index Questionnaire

Please circle the number which best describes your typical level of activities. A score of 0 means no disability at all, and a score of 10 signifies that all activities in which you would normally be involved in have been totally disrupted or prevented.

FAMILY / HOME RESPONSIBILITIES: This category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving children to school).

Completely able to function 0 1 2 3 4 5 6 7 8 9 10 *Totally unable to function*

RECREATION: This category includes hobbies, sports, and other similar leisure time activities.

Completely able to function 0 1 2 3 4 5 6 7 8 9 10 *Totally unable to function*

SOCIAL ACTIVITIES: This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

Completely able to function 0 1 2 3 4 5 6 7 8 9 10 *Totally unable to function*

OCCUPATION: This category refers to activities that are part of or directly relate to your job. This includes nonpaying job as well, such as that of a homemaker or volunteer worker.

Completely able to function 0 1 2 3 4 5 6 7 8 9 10 *Totally unable to function*

SELF CARE: This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed).

Completely able to function 0 1 2 3 4 5 6 7 8 9 10 *Totally unable to function*

LIFE-SUPPORT ACTIVITIES: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

Completely able to function 0 1 2 3 4 5 6 7 8 9 10 *Totally unable to function*