

Ahwatukee *Life!* Center

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Auto Accident Information

Patient Name _____ Today's Date: ____/____/____

Patients Age _____ Date of Birth ____/____/____ Height _____ Weight _____

Place of Accident: _____/____/____ Date of Accident ____/____/____ Time: _____
City AM / PM

Were Police Notified? YES NO Was a Report Taken? YES NO

Brief description of accident _____

Road condition at the time of the accident WET DRY ICY OTHER _____

HOSPITAL INFORMATION

Did you go to the Hospital? YES NO

If yes, which hospital? _____

How did you get there? Ambulance Other

Were you x-rayed? YES NO If yes, what part of body _____

Were you treated at the hospital? YES NO If yes, what treatment? _____

YOUR VEHICLE INFORMATION

Your vehicle make _____ model _____ year _____

Was your car stopped at the time of impact? YES NO

If yes, was the driver's foot on the brake? YES NO

If NO, estimate the speed of the vehicle you were in: _____ mph

If your vehicle was moving at the time of impact, was it:

slowing down? YES NO

gaining speed? YES NO

traveling at a steady rate of speed? YES NO

Was your vehicle totaled? YES NO DON'T KNOW YET

If not, what is the estimated cost of the damage? \$ _____

Which of the following car parts broke due to the accident? WINDSHIELD RIGHT/LEFT SIDE WINDOW
STEERING WHEEL FRONT/BACK SEAT OTHER

THE OTHER VEHICLE'S INFORMATION

Other vehicle make _____ model _____ year _____

Was the other vehicle moving at the time of the collision? YES NO If yes, approx. _____
MPH

If the other vehicle was moving at the time of collision, was it:

slowing down? YES NO

gaining speed? YES NO

traveling at a steady rate of speed? YES NO

What damage was sustained by the other vehicle? _____

INSIDE YOUR VEHICLE

Which seat were you in? Driver Front Passenger Back seat Left Middle Right

Were seat belts used? YES NO Lap Shoulder

Does the vehicle have airbags? YES NO If yes, did they deploy? YES NO

Does the vehicle have headrests? YES NO If yes, does the top of the headrest hit your head:

Bottom of your head

Middle of your head

Top of your head

Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise?

AWARE UNAWARE

Was the trunk of your body pointed straight forward at the time of the collision? YES NO

If no, how was it turned? _____

Was your head pointed straight forward? YES NO If no were, you looking Left Right

Were you looking in the rear view mirror? YES NO

What part of the vehicle did your following body parts hit?

head hit chest hit

right/left shoulder hit right/left arm hit

right/left hip hit right/left leg hit

right/left knee hit other

YOUR INJURIES

Did you lose consciousness? YES NO

Did you experience a flash of light? YES NO

Did you break any bones? YES NO If yes, which bones? _____

Did you sustain any cuts? YES NO If yes, where? _____

Did you sustain any bruises? YES NO If yes, where? _____

Did you receive any injury or bruise from the seat belt? YES NO

Did you receive any injury or bruise from the air bag? YES NO

Did you become: confused, disoriented, light headed, dizzy, nauseated, blurred vision, ring/buzz in ears?

If you still have any of these symptoms, which ones? _____

Are you currently suffering from any of the following? restlessness, sleeplessness, difficulty concentrating, difficulty with memory, forgetfulness, irritability, reduced tolerance to heat, reduced tolerance to alcohol

What other injuries are you suffering from? _____

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Statement of Purpose

Ahwatukee Life! Center offers a unique opportunity for you and your family to discover the benefits of Chiropractic care and learn how this will assist you in obtaining your goal of optimum health.

Confidential Personal Information

Patient Name _____ Date of Birth ____/____/____ Age ____
SS# ____/____/____ Home Ph () ____-____ Cel Ph () ____-____
Address _____
Apt# _____ City _____ State _____ Zip _____
Occupation _____ Employer _____ Wk Ph () ____-____
(If Minor) Parent/Guardian's Name _____
Spouse's Name _____ Spouse's Employer _____
In case of emergency, call _____ Relationship _____ Phone () ____-____
Email address _____ How did you hear about our office?
 Referral _____ Google YellowPages Directory Ad Other

Health History

Chief Complaint _____
Other doctors seen for this condition _____
Is this condition/injury due to work injury or an automobile accident? Work Auto No
List all medications you are currently taking _____
History of all surgeries _____
Relevant family history: Diabetes Cancer High Blood Pressure Arthritis Heart Disease
Emphysema Stroke Other _____

Females Only Are you pregnant? No Yes Maybe

Have you had chiropractic care? No Yes, when was your last adjustment?

Signature X _____ Date _____

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Please **circle the number** that describes your pain

1-2-3=Little 4-5-6=Medium 7-8-9-10=Severe

SKELETAL

- Neck 1 2 3 4 5 6 7 8 9 10
- Headaches 1 2 3 4 5 6 7 8 9 10
- TMJ/Jaw 1 2 3 4 5 6 7 8 9 10
- Upper Back 1 2 3 4 5 6 7 8 9 10
- Shoulders 1 2 3 4 5 6 7 8 9 10
- Arms Lt/Rt 1 2 3 4 5 6 7 8 9 10
- Mid Back 1 2 3 4 5 6 7 8 9 10
- Low Back 1 2 3 4 5 6 7 8 9 10
- Hips Lt/Rt 1 2 3 4 5 6 7 8 9 10
- Legs Lt/Rt 1 2 3 4 5 6 7 8 9 10
- 1 2 3 4 5 6 7 8 9 10

Please **check all symptoms** you have currently
OR list the **date** when you last had the symptom.

DIGESTIVE

- Irritable Bowel Syndrome _____
- Heartburn _____
- Ulcers _____
- Gas/Bloating _____
- Constipation _____
- Diarrhea _____
- Frequent Nausea/Vomiting _____
- Gallbladder Problems _____
- Liver Problems _____
- Weight Trouble _____
- Abdominal Cramps _____
- _____

URINARY

- Kidney Stones _____
- Bladder Infections _____
- Urination Problems _____
- _____

Please **check all symptoms** you have currently
OR list the **date** when you last had the symptom.

NERVOUS SYSTEM

- Concussion _____
- Fainting _____
- Dizziness _____
- Numbness _____
- Buzz/Ring in Ears _____
- Confusion/Depression _____
- Paralysis _____
- Forgetfulness _____
- _____

CIRCULATORY

- High Blood Pressure _____
- Heart Problems _____
- Chest Pain _____
- Shortness of Breath _____
- Stroke _____
- _____

RESPIRATORY

- Asthma _____
- Allergies _____
- Sinus Infection _____
- Lung Problems _____
- _____

HORMONAL

- Thyroid Problems _____
- Estrogen _____
- Insulin/Diabetes _____
- _____

FUNCTIONAL RATING INDEX

Pain Disability Questionnaire

This index helps us understand how your condition has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do few activities	Cannot do any activities

Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed	Moderately disturbed	Greatly disturbed	Totally disturbed

Frequency of pain

0	1	2	3	4
No pain	Occasional pain 25% of the time	Intermittent pain 50% of the time	Frequent pain 75% of the time	Constant pain 100% of the time

Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain No restrictions	Mild pain No restrictions	Moderate pain Need to go slowly	Moderate pain Needs some assistance	Severe pain Need 100% assistance

Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

Travel (driving, etc)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Severe pain on long trips	Severe pain on short trips

Walking

0	1	2	3	4
No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work No extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Print Name _____

Total Score _____

Signature _____

Date _____

- The Functional Rating Index has been standardized in research settings for Neck and Back Pain injury problems. (Fiese and Menke, Spine: 26:78-87, Jan, 2001). It has been found to be more responsive, reliable, and easier to use than the well known 18 item Roland-Morris Disability Questionnaire. (Wunpen, et al, Spine:30:141-145, Jan 1, 2005)
- Ahwatukee Life Center is using this instrument as a clinical monitoring tool for all neuromuscular and orthopedic pain as well, including such problems as headaches, fibromyalgia, and extremity injuries.