

Auto Accident/Personal Injury Information

Patient's Name: _____

Today's Date: _____



Personal Injury Information

Date of Accident: _____ Time of Accident: _____ am/pm

Did police arrive on scene? Yes No Is there a report? Yes No

Your Vehicle: Year-_____ Make-_____ Model-_____

Was your foot on the brake? Yes No Speed at impact-_____ mph

Was your vehicle: Stopped Decelerating Accelerating Moving Steady _____ mph

Other Vehicle: Year-_____ Make-_____ Model-_____

Was the vehicle: Decelerating Accelerating Moving Steady, at _____ mph

Were you hospitalized? Yes No What hospital? _____

How were you transported? _____

What treatment did you receive? _____

X-ray MRI CT scan: What area? _____

Bleeding/Cuts? Yes No Where? _____

Bruises? Yes No Where? _____

Were you aware/surprised at impact? Aware Surprised

Were you wearing a seatbelt? Yes No Type: Lap belt Shoulder-Lap belt

Did you hit any part of the vehicle? Yes No What part/Where? _____

What symptoms did you have **immediately** after the accident? _____

What symptoms do you **currently** have? _____

Where did your vehicle sustain damage? _____

What is the estimated cost of damages? _____

Was your head pointing straight ahead? Yes No, which direction? _____

Was your trunk pointing straight ahead Yes No, which direction? _____

Has Fault Been Established? Yes No, Yours Others

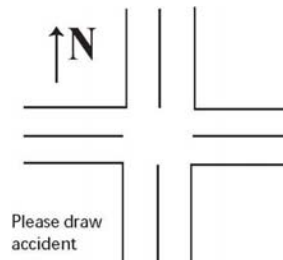
YOUR Insurance: _____ Adjustor: _____ Ph: _____

OTHER Insurance: _____ Adjustor: _____ Ph: _____

Attorney: _____ Ph: _____

Claim/Case Number: _____

Please describe what happened during the accident:



3715 East Overland Road ♦ Suite 105 ♦ Meridian, Idaho 83642

Phone: 208.888.0055 ♦ Fax: 208.888.5062

Dr. Suzi Cunningham, D.C., C.S.C.S. ♦ Dr. Travis Cunningham, D.C., C.S.C.S.

Work Accident Injury Information

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

Work Injury Information

Name of Employer: _____

Claim Number: _____ Insurance Company: _____

Insurance Adjustor: _____ Phone: _____

Date Filed: _____ Date of Injury: _____

Were you hospitalized? Yes No if yes, where? _____

How were you transported? _____

What treatment did you receive? _____

X-ray MRI CT scan: What area? _____

Did you receive any medication? Yes No If yes, please list; _____

What types of injuries did you sustain (cuts/bruises/fractures/sprains/etc.)? _____

What symptoms did you feel **immediately** after the accident? _____

What symptoms do you **currently** feel? _____

Attorney (if applicable): _____ Phone: _____

Please describe what happened during the accident:



Roland – Morris Acute Low Back Pain Disability Questionnaire

Name: (Please Print) _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

How long have you had low back pain? ___ years ___ months ___ weeks

Is this your first episode of low back pain? ___ yes ___ no

Use the letters below to indicate the type and location of your sensations right now.
(Please remember to complete both sides of this form.)

A = Ache

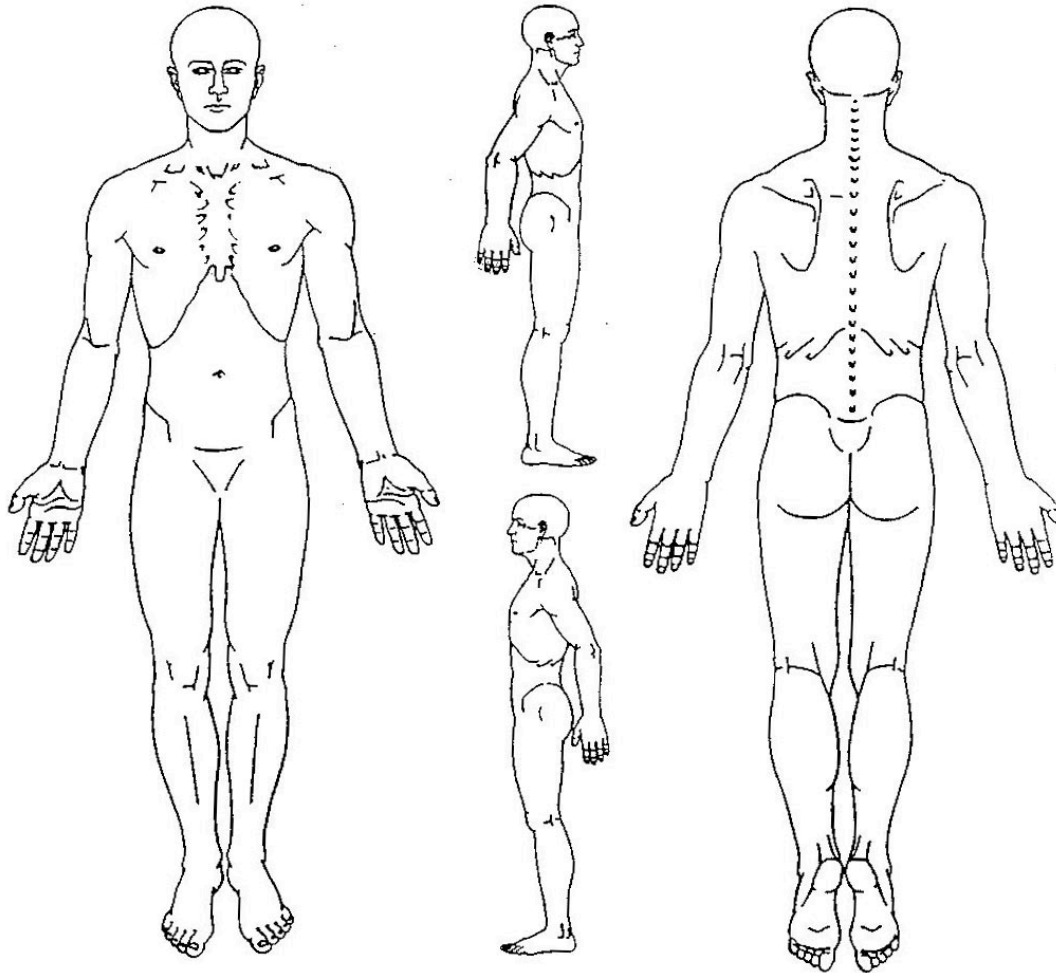
B = Burning

N = Numbness

P = Pins and needles

S = Stabbing

O = Other



Over Please

**ROLAND MORRIS ACUTE LOW BACK
PAIN DISABILITY QUESTIONNAIRE**

Name: _____

Date: ____ / ____ / ____

Please Read Instructions: When your back hurts, you may find it difficult to do some of the things you normally do.
Mark only the sentences that describe you today.

- I stay at home most of the time because of my back.
- I change position frequently to try to get my back comfortable.
- I walk more slowly than usual because of my back.
- Because of my back, I am not doing any jobs that I usually do around the house.
- Because of my back, I use a handrail to get upstairs.
- Because of my back, I lie down to rest more often.
- Because of my back, I have to hold on to something to get out of an easy chair.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly than usual because of my back.
- I only stand up for short periods of time because of my back.
- Because of my back, I try not to bend or kneel down.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all of the time.
- I find it difficult to turn over in bed because of my back.
- My appetite is not very good because of my back.
- I have trouble putting on my socks (or stockings) because of the pain in my back.
- I can only walk short distances because of my back pain.
- I sleep less well because of my back.
- Because of my back pain, I get dressed with the help of someone else.
- I sit down for most of the day because of my back.
- I avoid heavy jobs around the house because of my back.
- Because of back pain, I am more irritable and bad tempered with people than usual.
- Because of my back, I go upstairs more slowly than usual.
- I stay in bed most of the time because of my back.

With Permission: Roland M, Morris R. A study of the natural history of back pain. Part I: development of a reliable and sensitive measure of disability in low-back pain. Spine 1983 Mar;8(2):141-4.

NECK DISABILITY INDEX QUESTIONNAIRE

Name: _____

Date: ____ / ____ / ____

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each section by selecting the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **Please just select the one choice which closely describes your problem *right now*.**

SECTION 1 - Pain Intensity

- A. I have no pain at the moment.
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

SECTION 2 - Personal Care

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

SECTION 3 - Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.

SECTION 4 - Reading

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

SECTION 5 - Headache

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come infrequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

SECTION 6 - Concentration

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty in concentrating when I want to.
- F. I cannot concentrate at all.

SECTION 7 - Work

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

SECTION 8 - Driving

- A. I can drive my car without neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive my car at all because of severe pain in my neck.
- F. I cannot drive my car at all.

SECTION 9 - Sleeping

- A. I have no trouble sleeping.
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10 - Recreation

- A. I am able to engage in all recreational activities with no pain in my neck at all.
- B. I am able to engage in all recreational activities with some pain in my neck.
- C. I am able to engage in most, but not all recreational activities because of pain in my neck.
- D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities at all.