

NEUROPLUS INSTITUTE PERSONAL INJURY QUESTIONNAIRE
(PLEASE BE VERY SPECIFIC WITH YOUR ANSWERS...THANK YOU!)

Last Name _____ First Name _____ Middle _____
 Home Phone _____ Work Phone _____
 Street Address and Number _____
 Mailing Address if Different _____
 City, State, and Zip Code: _____
 Age: _____ Date of Birth _____ Social Security # _____ - _____ - _____ : E-mail: _____
 Sex: **MALE** **FEMALE** # of Children _____ Married _____ Single _____ Widowed _____ Divorced _____
 Occupation _____ Employer _____
 Drivers License # _____ State _____
 In Case of Emergency, Please contact: Name _____ Phone _____
 Do you have an attorney representing you for your accident: **YES** _____ **NO** _____ **Who?** _____

CHIEF COMPLAINT:

Please number your symptoms (1 is the most severe) that you have developed since the accident.

_____ Headaches	_____ Numbness in feet R / L Both	_____ Loss of Memory	_____ Pain Behind Eyes
_____ Neck Pain/Stiffness	_____ Arm Weakness R/L Both	_____ Dizziness	_____ Jaw Popping
_____ Leg Weakness R/L Both	_____ Mid Back Pain	_____ Sleeping Problems	_____ Numbness in fingers
_____ Facial Pain	_____ Low Back Pain	_____ Eyes Light Sensitive	_____ Fainting
_____ Irritability	_____ Arm Pain R / L Both	_____ Fatigue	_____ Breath Shortness
_____ Loss of Balance	_____ Leg Pain R / L Both	_____ Depression	_____ Ringing/Buzzing
_____ Cold Feet	_____ Muscle Spasm/Cramping	_____ Cold hands	_____ Chest Pain
_____ Shoulder L or R Both	_____ Diarrhea	_____ Constipation	_____ Other _____

Which of these symptoms did you have before the Crash?# _____ # _____ # _____ Are they Worse? **Yes** **No**

HISTORY:

- What was the Date of the Accident? _____ Time: _____ AM/PM
- Were you the Driver or Passenger or Pedestrian
- If you were the **passenger** where were you sitting: **FRONT, BACK DRIVER SIDE, BACK PASSENGER SIDE**
- Cars involved in accident Year, Type, Model, and Estimated speed.

Your Car	Year _____	Type _____	Model _____	Speed _____
Other Car	Year _____	Type _____	Model _____	Speed _____
Other Car	Year _____	Type _____	Model _____	Speed _____
- Type of Accident: Head-on Collision Broad-side Collision Front Impact Rear-end car in front of you
 Rear Impact Non-collision
- Please describe the accident in your own words! (Be very specific!!) _____

- Head/Body position at time of impact:
 Head turned left Head turned right Body straight in sitting position
 Head looking back Body rotated right Body rotated left
 Head straight forward Other: _____
- Were you wearing your seat belt? YES NO
- Did you see the accident coming? YES NO
- Did you brace yourself for impact? YES NO
- Upon impact, do you recall striking any objects inside of the car? Yes No
 If yes, what objects did you strike? _____
- Since the accident, are conditions becoming: BETTER WORSE SAME
- Describe your symptoms: CONSTANT COMES & GOES
- Please describe what symptoms you felt:
 Immediately after the accident: _____
 Later that day: _____
 The next day: _____
- Have your symptoms persisted since the point of impact? Yes No
- Did the EMS arrive at the scene? Yes No
 If yes, were you treated by them? Yes No
 Did the EMS take you to the hospital? Yes No Other: _____
 Did you go to the hospital on your own? Yes No

18. Who was the 1st Doctor that treated you?

Name: _____

Date seen: _____

Were you examined? Yes No

Were X-rays taken? Yes No Were you: Sitting or Standing

Did you receive treatment? Yes No Medications Braces Collars

If yes, what kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

19. What relieves your symptoms? _____

20. What aggravates your symptoms? _____

21. Road conditions at time of accident: Icy Rainy Wet Clear Dark Other (describe): _____

22. Visibility at the time of the accident? Poor Fair Good Other: _____

23. Where was your car struck? _____

24. Were you wearing a hat or glasses? Yes No

If yes, where were they located after the accident? _____

25. Did you get any bleeding cuts? Yes No If yes, where? _____

26. Did you get any bruises? Yes No If yes, where? _____

27. As a result of the accident you were: Rendered unconscious In shock Dazed, circumstances vague Other: _____

28. Do you have an attorney representing you for this claim? Yes No

If yes, who? _____

PAST MEDICAL HISTORY:

29. Do you have any prior history of any of the symptoms you checked above? Yes No If yes explain: _____

30. Have you ever had any prior automobile accidents or ever had any serious falls/injuries? If yes, please give dates and treatments: _____

31. What Medications are you currently taking? _____

Taken in last 6 months? _____

32. Have you ever had any surgeries or been hospitalized overnight? If yes, please give details: _____

33. Are you currently under the care of any other doctors for any Health related concerns? If yes, please describe. _____

34. Have you ever seen a Chiropractor before? If yes, then who, where & what treated for? _____

FAMILY HISTORY:

35. Place a (X) if any family member has suffered from:

Tuberculosis Kidney Disease Spinal Disorder

Mental Illness Epilepsy Diabetes

Gout Allergy Arthritis

High Blood Pressure Cancer Migraines

Heart Attacks Other, list: _____

36. Who is your family physician for regular check-ups? _____

Date last seen? _____ What treatment? _____

37. Are you pregnant? YES NO

SIGNATURE OF PATIENT: _____ DATE: _____

NECK DISABILITY INDEX

Name: _____ Date: _____ File #: _____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

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

SECTION 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4 – Reading

- I can read as much as I want with no pain in my neck.
- I can read as much as I want with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all due to pain.

SECTION 5 – Headaches

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

SECTION 6 – Concentration

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

SECTION 7 – Work

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

SECTION 8 – Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

SECTION 9 – Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hr sleepless).
- My sleep is mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (2-3 hrs sleepless).
- My sleep is greatly disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.

From Vernon H, Minor S. JMPT 1991; 14(7):409-415

REVISED OSWESTRY INDEX

Name: _____ Date: _____ File #: _____

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 – Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4 – Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5 – Sitting

- I can sit in any chair as long as I like without pain.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain immediately.

SECTION 6 – Standing

- I can stand as long as I want without pain.
- I have some pain standing, but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

SECTION 7 – Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than ¼.
- Because of pain, my normal night's sleep is reduced by less than ½.
- Because of pain, my normal night's sleep is reduced by less than ¾.
- Pain prevents me from sleeping at all.

SECTION 8 – Social Life

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing . . .
- Pain has restricted my social life and I do not go much.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

SECTION 9 – Traveling

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain prevents all forms of travel except done lying down.
- Pain restricts all forms of travel.

SECTION 10 – Changing Degrees of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but slowly improves.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.