ACCIDENT CHIROPRACTORS
Main Office: 13757 W. Bell Rd. • Ste 101 • Surprise, AZ 85374
Telephone: (602) 253-8888 **Facsimile: (602) 252-0845**

PATIENT HISTORY & REGISTRATION FORM

Name: _____ Age: _____ Date of Birth: _____ Date: _____
LAST FIRST MIDDLE

Address: _____ Social Security #: _____

City, State, Zip: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell: (_____) _____ E: Mail: _____

Employer: _____ Spouse's Name: _____

Occupation: _____ Spouse's Employer: _____

In case of emergency, notify _____ **Relationship:** _____ **Phone** (____) _____

Reason for Office Visit: _____

Please list all medications and dosage: **Frequency** **For What Illness?**

_____

_____

_____

List any allergies to medications, foods or other: _____

Are you pregnant? ☐ Yes ☐ NO First day of last menstrual cycle: _____

Do you smoke? ☐ Yes ☐ No; How much? _____ Do you drink alcohol? ☐ Yes ☐ No; How Much? _____

Please list any recent X-rays, lab or other tests: **Date** **Facility/Doctor**

_____

_____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / MS	☐ Yes
Colon Disease	☐ Yes	Stroke	☐Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Depend	☐ Yes	AIDS	☐ Yes

Patient's Name: _____ Date: _____

PLEASE MARK (X) AS MANY OF THE FOLLOWING STATEMENTS THAT APLY TO YOUR CASE.

- ☐ I have Medical Payment (Med-Pay) benefits, either, personally or through the driver of my vehicle.
- ☐ I have group health insurance benefits either directly or through my spouse or parents.
- ☐ I have retained an attorney,
- ☐ I have not retained an attorney.
- ☐ I have the adverse or third party information available. (Insurance company of the other driver.)

PLEASE PROVIDE THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Insured: _____

Claim #: _____ Policy: _____

Telephone: _____ Fax: _____

2) YOUR GROUP HEALTH INSURANCE COMPANY: _____

Address: _____ Insured: _____

Date of Birth: _____ Policy: _____ SS #: _____

Telephone: _____ Fax: _____

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Insured: _____

Claim #: _____ Policy: _____

Telephone: _____ Fax: _____ Claim Rep: _____

4) ATTORNEY: _____ Legal Assistant: _____

Address: _____

Telephone: _____ Fax: _____

HIPAA COMPLIANCE

Goldberg Chiropractic is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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Name: _____ Date: _____

Reason for today's visit: _____

Date the symptoms began: _____

Are your symptoms due to: ☐ Auto accident ☐ Work ☐ Sports ☐ Other _____

Explain: _____

Other health care providers seen for these symptoms and when: _____

In what way does this interfere with your normal activities and / or work? _____

_____

When are you most uncomfortable? ☐ Morning ☐ Afternoon ☐ Evening ☐ During the night ☐ Other _____

What activities or positions make your symptoms worse?

☐ Sitting ☐ Standing ☐ Lying Down ☐ Bending ☐ Lifting ☐ Walking ☐ Other _____

What makes your symptoms feel better? _____

Describe the **quality(s)** of your symptoms: ☐ Dull ☐ Sharp ☐ Throbbing ☐ Ache ☐ Burning ☐ Numbness ☐ Tingling

How often are your symptoms: ☐ Occasionally (0 – 25% of the time) ☐ Intermittently (26 – 50% of the time)

☐ Frequently (51 – 75% of the time) ☐ Constantly (76 –100% of the time)

Please indicate with a "√" the appropriate box for any of the following symptoms, which you now are experiencing from the accident.

	MUSCULOSKELETAL				NERVOUS SYSTEM
	Headaches				Numbness
	Neck Pain				Cold /tingling extremities
	Upper back pain				Paralysis
	Shoulder pain	L	R		Dizziness
	Arm pain	L	R		Fainting
	Arm numbness	L	R		Depression
	Hand pain	L	R		Forgetfulness
	Hand numbness	L	R		Fatigue
	Mid back pain				Stress
	Chest pain				Loss of Sleep
	Low back pain				Convulsions
	Hip pain	L	R		**EYE, EAR, NOSE,THROAT**
	Sciatic nerve pain	L	R		Vision problems
	Tailbone pain				Ear infections, ear ache L R
	Leg pain	L	R		Hearing loss
	Leg numbness	L	R		Nose pain / bleeding
	Knee or foot pain	L	R		Breathing problems
	Sore muscles				Dental problems
	Walking Problems				**RESPIRATORY**
	Fractured Bones				Difficulty breathing
	Metal screws/implants				Asthma
	Weak muscles				Chronic cough
	Stiffness				Chest pain

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AUT0 ACCIDENT CONSULTATION / HISTORY

Date of Accident: _____ Date of Exam: _____ Doctor: _____

PLEASE FILL IN OR CIRCLE ALL QUESTIONS ASKED

Patient's Name: _____
Have you missed work due to the accident? YES NO If Yes, Dates missed: _____
Was the accident on-the-job? YES NO
Were you the: Driver Front Seat Passenger Rear Seat Passenger
Motorcycle Operator Motorcycle Passenger Other: _____
Vehicle was driven by: _____
Did your car strike another? YES NO Did the other car strike You? YES NO
Were you struck from: BEHIND DRIVER'S SIDE PASSENGER'S SIDE FRONT Other _____
Were police on the scene? YES NO If Yes, was a report made? YES NO
Were traffic citations issued to: You--- Driver of your car----Driver of the other car---None---Unknown
Accident Description & Chief Complaint:

_____
_____
_____

Was your car heading: North South East West on _____(Street/Highway)
Was the other car heading: North South East West on _____ (Street/Highway)
Your Vehicle (Year, Make, Model) _____
Your estimated speed at the moment of impact: Full Stop Slowing Accelerating Constant Speed
Other Vehicle (Year, Make, Model) _____
Time of Day: Daylight Dawn Dusk Dark
Road Conditions: Dry Damp Wet Snow Ice Other _____
Head Rests Restraints: YES NO Adjustable: UP Down Don't Know
If adjustable, was the position altered by the accident? YES NO
Was the seat back adjustment altered by the accident? YES NO
Were seat belt restraints used? YES NO Type: LAP LAP and SHOULDER CAR SEAT
Did air bag deploy? YES NO If Yes, were you struck? YES NO Were you Burned? YES NO
Body position: Good Forward lean Other _____
Head position: Forward Left _____ Right _____ Up _____ Down _____
Hands: One on wheel Two on wheel N/A
Brakes applied at impact? YES NO
Aware of impending crash? YES NO

During the Crash:

Did you strike any body parts in the vehicle? YES NO If Yes, describe _____
Did vehicle strike any objects after the crash? YES NO If Yes, describe _____
Were you wearing a hat or glasses? YES NO If Yes, were they still on after the crash? YES NO
Where did you go after the accident? Home Work Hospital Mode of transportation _____
Emergency room: YES NO Hospital name: _____
X-rays Taken: YES NO Body parts X-rayed _____
Cervical collar given: YES NO Ice given: YES NO
Rx or Medication given: YES NO Type: _____
Other Doctors / Clinics / Therapists: (Seen since the Accident Excluding Above Information)

Doctor: _____ Specialty: _____ Date first seen: _____

Doctor: _____ Specialty: _____ Date first seen: _____

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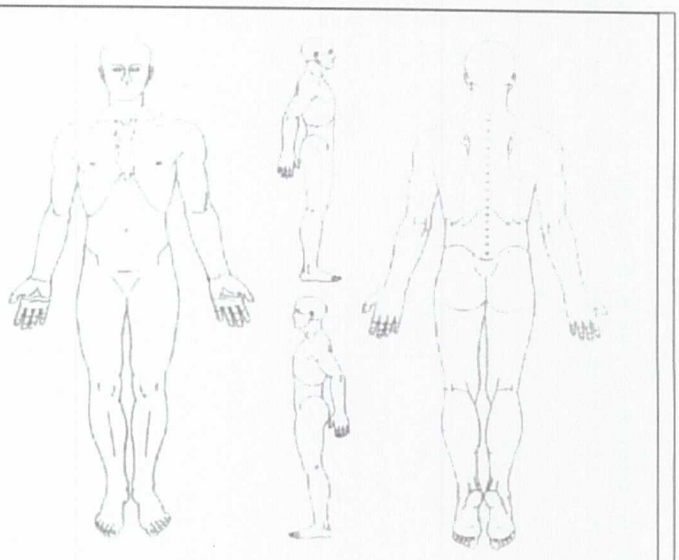
Patient: (Print) _____ **Date:** _____ **Office:** _____

Please mark on the diagram to the right the following symbols as they relate to the patients' symptoms:

SS = spasms	**ST = stiffness**
DP = dull pain	**SP = sharp pain**
SH = shooting pain	**TI = tingling**
NU = numbness	**O = other**



Re-Schedule Y N Provider Signature _____ **Date** _____ **OV#** _____

Case Type: ☐ **MVA** ☐ **WC** ☐ **GH** ☐ **CASH**

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Chiropractic care is a non-surgical, non-invasive procedure and has one of the safest records in health care. As with any health care specialty, we cannot promise a cure but we will give you our best care and we will discuss any questions or concerns with you.

I, the undersigned, do hereby give my voluntary consent for the administration of Chiropractic adjustments/treatments. I have been informed that an assistant can be in attendance during the time of any physical examination, especially at my request. I have been informed that it is possible that a hand or arm may come in contact with the breast or gluteal muscles when an adjustment is performed. I accept the fact that I may withdraw this consent or stop treatment at any time.

I acknowledge that I have discussed non-surgical chiropractic care and physiological therapeutics and I authorize Accident Chiropractors to provide such care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patients may experience temporary symptoms such as an increase in soreness following a massage, manipulation or traction. In addition, physiotherapy such as ice, heat or ultrasound may irritate the skin.

To Be Completed By Patient:

Print Patient's Name: _____

Signature of Patient: _____ Date Signed: _____

To Be Completed By Patient's Representative if Patient is a Minor or is Physically or Legally Incapacitated:

Print Name of Patient's Representative: _____

Print Relationship to Patient: _____

Signature of Patient's Representative: _____ Date Signed: _____

Physician Signature: _____ Date Signed: _____

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AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I, _____, (Patients Name) authorize the release of any information that Accident Chiropractors deems appropriate concerning my physical condition for reimbursement of charges incurred.

In that this office is waiting for payment of some or its entire fee, I agree to provide Accident Chiropractors. with information and forms regarding any potential source of fee payment to assist in any way I can. I hereby assign to Accident Chiropractors my rights to receive payment from negligent parties, health insurance, my auto medical pay, or any additional insurance companies that will pay this claim. **Payments should be made payable to and mailed to:**

Accident Chiropractors
3326 North 7th Street, Phoenix, Arizona 85014

If my policy prohibits assignment, then checks should be made jointly to me (patient) and Accident Chiropractors and mailed to the above address.

I authorize my attorney, direct payment to Accident Chiropractors, any sum I now or hereafter owe out of the proceeds of any settlement of my case and/or any insurance company obligated to pay me (patient) or based in whole or in part upon the charges made for Accident Chiropractors services.

I permit Accident Chiropractors to endorse co-issued remittance checks for the convenience of crediting my account.

In the event any insurance company, obligated by contractual agreement is to make payment to me towards my services and refuse to make such payment on demand, I hereby assign and transfer to Accident Chiropractors, the cause of action that exists in my favor against any such companies (The Names) of which is believed to be correctly set forth under pertinent data and authorize Accident Chiropractors to prosecute said action in my name as they see fit and further authorize Accident Chiropractors to compromise, settle or otherwise resolve said claim.

I understand that whatever amounts you do not collect from the Insurance Company's proceeds, whether it is all or part of what is due; I personally owe and agree to pay Accident Chiropractors.

In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in the State of Arizona.

I further agree that this authorization and assignment is irrevocable and ongoing until all monies owed are paid in full.

This authorization and assignment will be in continual effect until revoked by both parties.

This document shall not be superseded by any other document sent, if any, by my attorney pertaining to disbursement of funds for my medical bills.

A photocopy of this form shall be valid as the original.

In the event of default, I agree to pay for collections, a minimum of 33 1/3% plus attorney fees.

Accident Chiropractors does not accept or bill Medicare and AHCCCS.

Print Patient's Name: _____

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

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VERIFICATION OF NON PREGNANCY

Date: _____

Name: _____

Address: _____

_____

Telephone Number: _____

Social Security Number: _____

Last Menstrual Cycle: _____

By my signature on this form, I, _____, do hereby state, that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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PHYSICAL EXAM

Name: _____ Date: _____

Complaints: MVA - WC _____
Height: _____ Weight: _____

PALPATION: Cervical _____ Thoracic _____
Lumbar _____ SI Joint (L/R) _____

OBSERVATION: Posture _____ Gait _____ Antalgic Posture _____

Active - Visual		Date:		Date:	
CERVICAL ROM					
Flexion	/50				
Extension	/63				
Lateral Flexion	/45	L	R	L	R
Rotation	/80	L	R	L	R
CERVICAL TESTING					
George's Test		+ / -		+ / -	
Foraminal Compression		+ / -		+ / -	
Shoulder Depression		+ / -		+ / -	
Soto-Hall Test		+ / -		+ / -	
NEUROLOGIC TESTING		**LEFT**	**RIGHT**	**LEFT**	**RIGHT**
Upper Extremity Pinwheel					
Biceps Reflex					
Triceps Reflex					
Brachioradialis Reflex					
LUMBAR ROM					
Lateral Flexion	/25	L	R	L	R
Flexion	/60				
Extension	/25				
LUMBAR TESTING					
Kemp's Test		+ / -		+ / -	
Bechtrew's Test		+ / -		+ / -	
Nachlas Test		+ / -		+ / -	
Hibb's Test		+ / -		+ / -	
SLR Test		+ / -		+ / -	
Fabere-Patrick Test		+ / -		+ / -	
Trendeleberg Test		+ / -		+ / -	
Minor's Sign		+ / -		+ / -	
NEUROLOGICAL TESTS		**LEFT**	**RIGHT**	**LEFT**	**RIGHT**
Lower Extremity Pinwheel					
Patellar Reflex					
Achilles Reflex					
Babinski Sign					

Comment: _____
_____

Doctor's Signature _____ Date: _____ Doctor's Signature _____ Date: _____

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Patient: _____ **Age:** _____ **DOB:** _____

Physician: _____ **Date:** _____

DIAGNOSIS

CERVICAL

- ☐ 307.81 Tension Headaches
- ☐ 310.2 Post Concussion Syndrome
- ☐ 346.9 Migraine Headaches
- ☐ 721.0 Cervical Osteoarthritis
- ☐ 722.4 Neurovascular Compression Syndrome
- ☐ 723.1 Cervical Disc Degeneration
- ☐ 756.2 Cervical Rib
- ☐ 784.0 Vascular Headaches
- ☐ 847.0 Cervical Sprain/Strain
- ☐ _____

THORACIC

- ☐ 353.0 Thoracic Outlet Syndrome
- ☐ 354.8 Intercostal Neuralgia
- ☐ 721.2 Thoracic Osteoarthritis
- ☐ 722.51 Thoracic Disc Degeneration
- ☐ 847.1 Thoracic Sprain/Strain
- ☐ 848.3 Rib Sprain/Strain
- ☐ _____

LUMBAR

- ☐ 721.3 Lumbar Osteoarthritis
- ☐ 722.10 Sciatica with Disc Displacement
- ☐ 722.2 Lumbar Prolapse/Protrusion/Herniation
- ☐ 722.52 Lumbar Disc Degeneration
- ☐ 724.3 Sciatica
- ☐ 724.6 Sacralgia
- ☐ 724.8 Facet Syndrome
- ☐ 756.11 Spondylosis
- ☐ 756.12 Spondylolisthesis Lumbosacral
- ☐ 846.0 Lumbosacral Sprain/Strain
- ☐ 846.1 Sacroiliac Sprain/Strain
- ☐ 847.2 Lumbar Sprain/Strain
- ☐ _____

GENERAL

- ☐ 719.58 Restricted Range of Motion
- ☐ 728.85 Muscle Spasms
- ☐ 729.1 Myalgia, Unspecified
- ☐ 736.81 Short Leg-Acquired
- ☐ 737.10 Kyphosis-Acquired
- ☐ 737.2 Lordosis-Acquired
- ☐ 737.3 Scoliosis-Acquired
- ☐ 754.2 Lordosis-Congenital
- ☐ 754.3 Scoliosis-Congenital
- ☐ 755.3 Short Leg-Congenital

EXTREMITIES

- ☐ 354.0 Carpal Tunnel Syndrome
- ☐ 716.96 Inflammation of Knee Joint
- ☐ 726.1 Adhesive Capsulitis
- ☐ 726.10 Rotator Cuff Syndrome
- ☐ 726.19 Subacromial Bursitis
- ☐ 726.31 Medial Epicondylitis
- ☐ 726.32 Lateral Epicondylitis
- ☐ 726.9 Tendinitis
- ☐ 840.0 A-C Sprain/Strain
- ☐ 840.9 Shoulder Sprain/Strain
- ☐ 841.9 Elbow Sprain/Strain
- ☐ 842.01 Wrist Sprain/Strain
- ☐ 842.1 Hand/Finger Sprain/Strain
- ☐ 843.9 Hip Sprain/Strain
- ☐ 844.9 Knee Sprain/Strain
- ☐ 845.00 Ankle Sprain/Strain, Unspec.
- ☐ 848.1 TMJ Sprain/Strain
- ☐ E812.0 MVA, Driver
- ☐ E812.1 MVA, Passenger
- ☐ _____
- ☐ _____
- ☐ _____

Duties Performed Under Duress at Work and Home

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all that apply to your WORK *because of the accident.*

- ☐ I go to work but work in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the Computer at work hurts
- ☐ Pushing at work hurts
- ☐ Pulling at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ _____
- ☐ _____

- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't used to
- ☐ I hide my poor work performance from my boss
- ☐ _____
- ☐ _____

Please check all that apply to your HOME/DOMESTIC duties *because of the accident.*

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot wash dishes now
- ☐ Vacuuming hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ _____
- ☐ _____

- ☐ I cannot take time off because I care for children
- ☐ I have _____ children ages _____
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the work now
- ☐ Others living with me do my share of the yard work
- ☐ Others living with me do my share of the gardening
- ☐ _____
- ☐ _____

_____

Signature Date

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (p. 1 of 2)

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all that apply to your EXERCISE & SPORTS Activity *because of the accident.*

- ☐ My exercise was affected by this crash
- ☐ I go to the gym & work out in pain
- ☐ I no longer go to the gym to work out
- ☐ I run but in pain
- ☐ I no longer run
- ☐ I take walks & have pain while walkiing
- ☐ I no longer take walks
- ☐ I used to make income at sports
- ☐ I have lost sports income since crash
- ☐ I am an amateur athlete
- ☐ I am a professional athlete
- ☐ _____
- ☐ _____
- ☐ I have gained _____ pounds since the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks

Please check all that apply to your HOBBY Activities *because of the accident.*

- ☐ My hobbies were affected by accident
- ☐ Hobby #1 _____
- ☐ I can't do hobby #1 anymore
- ☐ I do hobby #1 but in pain
- ☐ I have lost money from not doing #1
- ☐ I didn't do hobby #1 for _____ weeks
- ☐ Hobby #2 _____
- ☐ I can't do hobby #2 anymore
- ☐ I do hobby #2 but in pain
- ☐ I have lost money from not doing #2
- ☐ I didn't do hobby #2 for _____ weeks
- ☐ Hobby #3 _____
- ☐ I can't do hobby #3 anymore
- ☐ I do hobby #3 but in pain
- ☐ I have lost money from not doing #3
- ☐ I didn't do hobby #3 for _____ weeks
- ☐ Hobby #4 _____
- ☐ I can't do hobby #4 anymore
- ☐ I do hobby #4 but in pain
- ☐ I have lost money from not doing #4
- ☐ I didn't do hobby #4 for _____ weeks
- ☐ _____

Please check all that apply to your TRAVEL Activities *because of the accident.*

- ☐ Business travel was affected by crash
- ☐ Pleasure travel was affected by crash
- ☐ I hurt driving in my own car
- ☐ I am in too much pain to drive
- ☐ I hurt when a passenger in a car
- ☐ I am in too much pain to sit in a car
- ☐ I have anxiety when I'm in a car
- ☐ I hurt when I'm on an airplane
- ☐ I am in too much pain to travel by plane
- ☐ Travel Plan #1 _____
- ☐ I did not go on travel plan #1
- ☐ I went, but did not enjoy #1 as much
- ☐ I went and the accident had no effect on #1
- ☐ Travel Plan #2 _____
- ☐ I did not go on travel plan #2
- ☐ I went, but did not enjoy #2 as much
- ☐ I went and the accident had no effect on #2
- ☐ I missed time with my family/friends b/c can't travel

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all the DAILY LIVING Activities that cause you pain *because of the accident.*

- ☐ Dressing
- ☐ Putting on pants
- ☐ Putting on shoes
- ☐ Tying my shoes
- ☐ Putting on shirt
- ☐ Drying my hair
- ☐ Combing my hair
- ☐ Washing my hair
- ☐ Taking a shower
- ☐ Taking a bath
- ☐ Leaning forward
- ☐ Laying in bed
- ☐ Sitting in my favorite chair
- ☐ Sleeping
- ☐ Going out with my friends
- ☐ Sitting in a restaurant
- ☐ Shopping
- ☐ Driving to/from work
- ☐ Sitting in Church
- ☐ Playing with my children
- ☐ Caring for my children
- ☐ Bending at the waist
- ☐ Sitting in a movie theater
- ☐ Exercise
- ☐ Eating
- ☐ Stooping
- ☐ Squatting down
- ☐ Kneeling
- ☐ Brushing my teeth
- ☐ Riding in a car
- ☐ Opening a jar
- ☐ Lifting a pan when cooking
- ☐ Closing the trunk on my car
- ☐ Opening the garage door
- ☐ Using my home computer
- ☐ Climbing stairs
- ☐ Going down stairs
- ☐ Sexual activity
- ☐ Turning my head to left or right
- ☐ Holding my head up all day
- ☐ Watching TV
- ☐ I have pain sitting & doing nothing
- ☐ Talking on the phone
- ☐ Reading
- ☐ Writing
- ☐ Opening doors
- ☐ Drying with a towel after a bath or shower
- ☐ Life has become a chore just to do normal things
- ☐ It is depressing to live like this
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Please check all that apply to your SCHOOL & EDUCATION Activities *because of the accident.*

- ☐ School was affected by the accident
- ☐ I am a student at _____
- ☐ I am in the _____ year/grade
- ☐ I was ☐ full time ☐ part time
- ☐ I am now ☐ full time ☐ part time
- ☐ I had to take fewer classes b/c of crash
- ☐ I missed _____ days of school
- ☐ I had to drop out of school b/c of crash
- ☐ My grades are lower since the crash
- ☐ I have pain carrying my school books
- ☐ I hurt sitting in class more than _____ minutes
- ☐ My neck hurts when I look down to read
- ☐ I don't learn as quickly as before the crash
- ☐ I don't learn things as well as before the crash
- ☐ I have difficulty concentrating in class
- ☐ It takes much longer to study/do my homework
- ☐ _____
- ☐ _____

_____ _____

Signature of Patient Date