INDIALANTIC CHIROPRACTIC & ACUPUNCTURE, INC.
322 FOURTH AVENUE, INDIALANTIC, FL 32903

PERSONAL INJURY FORM

NAME: ____ DATE:______________

ADDRESS: ______________________________________

____

CITY: __________________ STATE:_____ ZIP:________

GENDER: ☐ Male ☐ Female

DATE OF BIRTH: ________________

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widow

EMPLOYER:______________________________________

INSURANCE PROVIDER: __________________________

PRIMARY PHYSICIAN: ____________________________

MAY WE CONTACT YOUR PHYSICIAN? ☐ Yes ☐ No

CELL: (____)____________________________

SERVICE PROVIDER:
☐ AT&T ☐ Verizon ☐ Sprint ☐ T-Mobile ☐ Metro
☐ Virgin ☐ US Cell ☐ Cingular ☐ Boost

HOME: (____)______________________________

WORK: (____)______________________________

EMAIL: (____)_____________________________

REFERRED BY: ___________________________

EMERGENCY CONTACT INFORMATION

NAME:___________________________________

PHONE NUMBER: _________________________

Reason for Visit

☐ Chronic Condition ☐ Wellness/Maintenance ☐ Injury
☐ Automobile Accident ☐ Trauma ☐ Other_____________

Pain Diagnostic Questions

HOW/WHEN DID YOUR PAIN BEGIN? ____

WHERE ARE YOU EXPERIENCING THIS PAIN? ____

CHECK THE DESCRIPTION(S) WHICH BEST MATCHES THE KIND OF PAIN YOU ARE EXPERIENCING:
☐ DULL ☐ ACHING ☐ SHARP ☐ SHOOTING
☐ BURNING ☐ THROBBING ☐ DEEP NAGGING ☐ OTHER ______________

PAIN GRADE INTENSITY SCALE (0=None,10=Most)

0	1	2	3	4	5	6	7	8	9	10

HOW FREQUENT IS PAIN PRESENT?
☐ NOT OFTEN ☐ REGULARLY. BUT COMES AND GOES ☐ ALL THE TIME ☐ NO PAIN AT ALL

HOW LONG DOES IT LAST? ____

DOES ANYTHING MAKE THE PAIN BETTER OR WORSE?

☐ YES ☐ NO IF YES, WHAT? ____

DOES THIS PAIN RADIATE OR TRAVEL (SHOOT) TO ANY AREAS OF YOUR BODY?

☐ YES ☐ NO IF YES, WHERE? ____

DO YOU HAVE ANY NUMBNESS/TINGLING IN YOUR BODY? ☐ YES ☐ NO

HAVE YOU HAD AN X☐RAY, MRI, NCS, EMG, OR BLOOD TEST TO HELP DIAGNOSE THIS CONDITION?

☐ YES ☐ NO IF YES, WHERE? ____

HAVE YOU SOUGHT ANY TREATMENTS, MEDICATIONS, SURGERY, OR CARE FOR YOUR CONDITION?
☐ YES ☐ NO IF YES, EXPLAIN ____

HAVE YOU HAD ANY COLON, HEART, LUNG, URINARY, OR CHANGES TO ANY OTHER BODILY FUNCTION?

☐ YES ☐ NO IF YES, EXPLAIN ____

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Medical History

HAVE YOU EVER HAD A CHIROPRACTIC ADJUSTMENT OR ACUPUNCTURE TREATMENT BEFORE?
☐ YES ☐ NO
PLEASE LIST ANY SERIOUS OR CHRONIC MEDICAL ILLNESSES OR CONDITIONS:
____

PREVIOUS INJURY OR TRAUMA: ____

HAVE YOU EVER BROKEN ANY BONES?
☐ YES ☐ NO
IF YES, WHICH ONES?________________________
PLEASE LIST ANY ALLERGIES YOU HAVE:
____

DO YOU DRINK? ☐ YES ☐ NO
FREQUENCY: ______________________________
DO YOU SMOKE? ☐ YES ☐ NO
FREQUENCY: ______________________________

ARE YOU CURRENTLY TAKING MEDICATION AND/OR SUPPLEMENTS? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE A LIST OF MEDICATIONS AND/OR SUPPLEMENTS IN THE TABLE BELOW.

MEDICATION	REASON FOR TAKING

HAVE YOU EVER HAD ANY SURGERY, OPERATION, OR MEDICAL PROCEDURE? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE A LIST OF PROCEDURES IN THE TABLE BELOW.

SURGERY	DATE OF PROCEDURE

Family Health History

IS THERE ANY HEALTH HISTORY OR FAMILY HEALTH HISTORY THAT YOU FEEL IS IMPORTANT TO SHARE?
☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

IMMEDIATE FAMILY MEMBER	CAUSE OF DEATH	AGE

Social & Occupational History

OCCUPATION/ JOB DESCRIPTION: ____
____

RECREATIONAL ACTIVITIES: ____

I have read the above information & certify it to be true and correct to the best of my knowledge, and hereby authorize Edward Fleming D.C., Indialantic Chiropractic & Acupuncture, Inc. to provide medical care, in accordance with this state's statutes.

____ ______________
Patient/Parent/Guardian Signature Date

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PERSONAL INJURY FORM

Patient Injury Type

☐ Automobile ☐ Work-Related ☐ Slip-and-Fall ☐ Other____________

Accident Information

INSURANCE PROVIDER: ________________________________

NAME OF AGENT: ______________________________________

COMPANY ADDRESS: ___________________________________

____

DRIVER'S LICENSE NUMBER: ____________________________

HAVE YOU RETAINED AN ATTORNEY? ☐ Yes ☐ No

NAME OF ATTORNEY: _________________________

ATTORNEY'S ADDRESS: _______________________

____

Accident History

DATE OF ACCIDENT: _______________ TIME OF ACCIDENT: _______________ ☐A.M. ☐ P.M.

WHAT WERE THE WEATHER CONDITIONS?

____

IN YOUR OWN WORDS, PLEASE EXPLAIN WHAT HAPPENED: ____

____

____

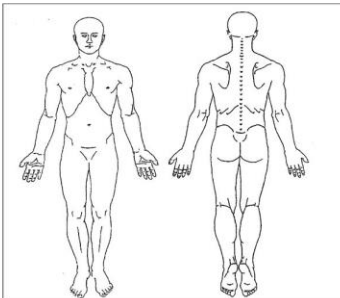
____

____

WHERE DID YOU FEEL THE PAIN?
MARK PAIN AREA ON THE BODY DIAGRAM.
(+ for Burning, 0 for Stabbing, - for Sharp, / for Constant)

HAVE YOU EVER BEEN INJURED IN A SIMILAR MANNER?
☐ YES ☐ NO IF YES, HOW AND WHEN?_________________

____



WHAT ARE YOUR CURRENT SYMPTOMS? ____________________________________

____

____

WERE YOU HOSPITALIZED AFTER THE INCIDENT? ☐ YES ☐ NO

IF YES, WHERE? ____

HOW LONG? ____

DID YOU RECEIVE TREATMENT FROM ANY OTHER HEALTH CARE SPECIALIST? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

SPECIALIST'S NAME AND TITLE: ____

KIND OF TREATMENT: ____

LENGTH OF TREATMENT: ____

HAVE YOU HAD ANY TIME LOSS FROM WORK? ☐ YES ☐ NO IF YES, FROM____________TO_______________

HAVE YOU HAD TO HAVE ANY OUTSIDE HELP? ☐ YES ☐ NO IF YES, WHAT TYPE?______________________

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PERSONAL INJURY FORM

Automobile Accident Questions

PLEASE USE THE GRID BELOW AND SYMBOLS PROVIDED TO DRAW THE STREET OR ROADWAY WHERE THE CRASH OCCURRED.

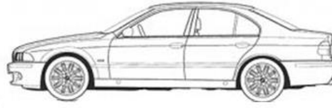
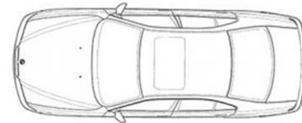
➡ **DIRECTION**

PEDESTRIAN/ NON-MOTORIST

SELECT ONE OF THE FOLLOWING IF YOUR CRASH DID NOT OCCUR ON A PUBLIC WAY:
- ☐ **Off-Street Parking Lot**
- ☐ **Garage**
- ☐ **Mall/Shopping Center**
- ☐ **Other______________**

WHAT KIND OF VEHICLE WERE YOU IN?
☐ Semi-Truck ☐ Truck ☐ Van/SUV ☐ Sedan ☐ Economy/Electric ☐ Motorcycle ☐ Other_________
MAKE:___________________ MODEL:__________________

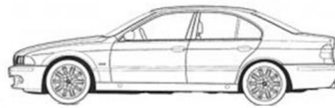
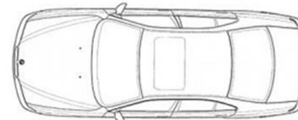
WAS THERE DAMAGE DONE TO YOUR VEHICLE? ☐ Yes ☐ No
IF YES, MARK "X's" ON THE DIAGRAMS BELOW TO IDENTIFY THE POINT(S) OF IMPACT:

DID YOUR VEHICLE GO OFF ROAD? ☐ Yes ☐ No
WHERE WERE YOU SITTING WHEN THE ACCIDENT OCCURRED?
☐ Driver ☐ Front Passenger ☐ Backseat Passenger (Driver's Side) ☐ Backseat Passenger (Passenger Side) ☐ Other_________
WERE OTHER PEOPLE IN THE CAR WITH YOU? ☐ YES ☐ NO IF YES, HOW MANY? ☐ 1 ☐ 2 ☐ 3 ☐ 4+
WERE ANY OF THEM INJURED? ☐ YES ☐ NO
IF YES, EXPLAIN: ____

WERE ANY OTHER VEHICLES INVOLVED? ☐ Yes ☐ No IF YES, HOW MANY? ☐ 1 ☐ 2 ☐ 3+
IF YES, PLEASE LIST THE VEHICLE(S) INVOLVED:
☐ Semi-Truck ☐ Truck ☐ Van/SUV ☐ Sedan ☐ Economy/Electric ☐ Motorcycle ☐ Other_________
MAKE:___________________ MODEL:__________________
☐ Semi-Truck ☐ Truck ☐ Van/SUV ☐ Sedan ☐ Economy/Electric ☐ Motorcycle ☐ Other_________
MAKE:___________________ MODEL:__________________

WAS THERE DAMAGE DONE TO THE OTHER VEHICLE? ☐ Yes ☐ No
IF YES, MARK THE DIAGRAMS BELOW WITH AN "X" TO IDENTIFY THE POINT(S) OF IMPACT:

STATE ANY STRANGE EVENTS THAT HAPPENED DURING OR IMMEDIATELY AFTER THE ACCIDENT:

____

____

SIGNATURE:______________________________ DATE:_________________

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PERSONAL INJURY FORM

NECK PAIN AND DISABILITY QUESTIONNAIRE (VERNON-MIOR)

This questionnaire has been designed to give your health care provider information as to how your neck pain has affected your ability to manage everyday life. Please answer ever section and mark in each section only the ONE box which applies to you. I realize you may consider that two of the statements in any one section relate to you, but please just mark the one which most closely describes your problem today.

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
☐I can look after myself normally without causing 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 I stay in bed.

SECTION 3- LIFTING
☐I can lift heavy weights without extra pain.
☐I can lift heavy weights but it causes extra pain.
☐Pain prevents me from lifting heavy weights off the floor, but I 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.
☐I cannot lift or carry anything at all.

SECTION 4- READING
☐I can read as much as I want with no neck pain.
☐I can read as much as I want with slight neck pain.
☐I can read as much as I want with moderate neck pain.
☐I can't read as much as I want because of moderate neck pain.
☐I can hardly read at all because of severe neck pain.
☐I cannot read at all.

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 headaches almost all the time.

SECTION 6- CONCENTRATION
☐I can concentrate fully when I want with no difficulty.
☐I can concentrate fully when I want with slight difficulty.
☐I have a fair degree of difficulty concentrating when I want.
☐I have a great deal of difficulty concentrating when I want.
☐I cannot concentrate at all.

SECTION 7- WORK
☐I can do as much work as I want.
☐I can 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.
☐I can't 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 hour sleepless).
☐My sleep is mildly disturbed (1-2 hours sleepless).
☐My sleep is moderately disturbed (2-3 hours sleepless).
☐My sleep is greatly disturbed (3-5 hours sleepless).
☐My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10- RECREATION
☐I am able to engage in all my recreation activities with no neck pain.
☐I am able to engage in all my recreation activities with some neck pain.
☐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 neck pain.
☐I hardly do any recreation activities because of neck pain.
☐I can't do recreation activities at all.

SIGNATURE:________________________ DATE:______________

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PERSONAL INJURY FORM

ROLAND-MORRIS LOW BACK PAIN QUESTIONNAIRE

When your back hurts, you may find it difficult to do some of the things you normally do. This list contains some sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you today. As you read the list, think of yourself **today**. When you read a sentence that describes you today, put a check mark by it. If the sentence does not describe you, then leave the space blank and go on to the next one. Remember, only place a check mark by the sentence if you are sure that it describes you today.

☐ 1. I stay at home most of the time because of my back.
☐ 2. I change position frequently to try and get my back comfortable.
☐ 3. I walk more slowly than usual because of my back.
☐ 4. Because of my back, I am not doing any of the jobs that usually do around the house.
☐ 5. Because of my back, I use a handrail to get upstairs.
☐ 6. Because of my back, I lie down to rest more often.
☐ 7. Because of my back, I have to hold onto something to get out of an easy chair.
☐ 8. Because of my back, I try to get other people to do things for me.
☐ 9. I get dressed more slowly than usual because of my back.
☐ 10. I only stand up for short periods of time because of my back.
☐ 11. Because of my back, I try not to bend or kneel down.
☐ 12. I find it difficult to get out of a chair because of my back.
☐ 13. My back is painful almost all of the time.
☐ 14. I find it difficult to turn over in bed because of my back.
☐ 15. My appetite is not very good because of my back pain.
☐ 16. I have trouble putting on my socks (or stockings) because of pain in my back.
☐ 17. I only walk short distances because of my back pain.
☐ 18. I sleep less well because of my back.
☐ 19. Because of my back pain, I get dressed with help from someone else.
☐ 20. I sit down for most of the day because of my back.
☐ 21. I avoid heavy jobs around the house because of my back.
☐ 22. Because of my back pain, I am more irritable and bad-tempered with people than usual.
☐ 23. Because of my back, I go upstairs more slowly than usual.
☐ 24. I stay in bed most of the time because of my back.

SIGNATURE:__________________________ DATE:______________

INDIALANTIC CHIROPRACTIC & ACUPUNCTURE, INC.
322 FOURTH AVENUE, INDIALANTIC, FL 32903

PERSONAL INJURY FORM

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

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 very severe.
☐The pain is severe and does not vary much.

SECTION 2- PERSONAL CARE

☐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 increases the pain, but I manage not to change my way of doing it.
☐Washing and dressing increases 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 causes extra pain.
☐Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently placed (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 when walking.
☐I have some pain walking, which 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.
☐I can only sit in my favorite chair as long as I like.
☐Pain prevents me from sitting more than one 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 right away.

SECTION 6- STANDING

☐I can stand as long as I want without pain.
☐I have some pain standing, but it doesn't increase with time.
☐I cannot stand longer than one hour without increasing pain.
☐I cannot stand longer than ½ hour without increasing pain.
☐I cannot stand longer than 10 minutes without increasing pain.
☐I avoid standing because it increases the pain right away.

SECTION 7- SLEEPING

☐I get no pain in bed.
☐I get pain in bed, but it doesn't prevent me from quality rest.
☐Because of pain, my normal night's sleep is reduced by ¼.
☐Because of pain, my normal night's sleep is reduced by ½.
☐Because of pain, my normal night's sleep is reduced by 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, etc.
☐Pain has restricted my social life and I don't go out often.
☐Pain has restricted my social life to my home.
☐I have hardly any social life because of the pain.

SECTION 9- TRAVELLING

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

SECTION 10- CHANGING DEGREE OF PAIN

☐My pain is rapidly getting better.
☐My pain fluctuates, but is definitively getting better.
☐My pain is getting better, but improvement is slow.
☐My pain is neither getting better nor worse.
☐My pain is gradually worsening.
☐My pain is rapidly worsening.

SIGNATURE:________________________ DATE:______________