Abshire Chiropractic Personal Injury Questionnaire

Name:_____ Date of Birth:_____
Date of Accident:_____ Time: _____ ○am / ◉pm City/State Occurred: _____
Street Location: _____
Type of accident (select & continue to appropriate section) ◉Auto Collision ○On the job injury ○Other_____

INSURANCE COMPANIES INVOLVED

My Company: _____
Company Responsible: _____
Have you been contacted by an insurance adjuster or company representative? Yes ◉ No ○
Do you have an attorney advising you in regards to this claim? Yes ◉ No ○
Did the attorney advise you in care at our office? Yes ◉ No ○
Attorney's Name: _____ Phone: _____
Address: _____ City/State: _____

ON THE JOB INJURY

If On the Job Injury, please describe the circumstances: _____
_____
_____
Was the injury reported to your foreman or employer? ○Yes ○No
Did they recommend our office for care? ○Yes ○No
Did you know the accident was coming? ○Yes ○No
Did you lose consciousness during the accident? ○Yes ○No
Did you go to a hospital? ○Yes ○No (If no skip to signature)
Were you hospitalized over night? ○Yes ○No
Did you receive any stitches for any cuts at the hospital? ○Yes ○No
Were Xrays taken at the hospital? ○Yes ○No If yes, which areas? _____
What you were prescribed at the hospital: ☐Pain Medicine ☐Muscle Relaxors ☐Neck Brace
What was the name of the hospital? _____
How did you get to hospital? _____
Signature: _____ **Date:**_____

AUTO COLLISION

What direction were you traveling in? _____
How many vehicles were involved? _____
What direction were you struck from? (check all that apply) ☐ Front ☐ Behind ☐ Left Side ☐ Right Side ☐ Auto was parked
As a result of the accident were you issued a ticket? ○Yes ○No
The driver of the other car? ○Yes ○No
The driver of the car you were in? ○Yes ○No
Did your car strike the other(s) involved? ○Yes ○No
OR did the other car strike yours? ○Yes ○No ○Undetermined
Did your vehicle hit anything after the accident? ○Yes ○No
If yes please describe: _____
Where were you sitting during the accident? ☐ Driver ☐ Front Passenger ☐ Rear Passenger Left ☐ Rear Passenger Middle ☐ Rear Passenger Right
Did you know the accident was coming? ○Yes ◉No
Did you lose consciousness during the accident? ○Yes ◉No
Did you have your seatbelt on during the accident? ○Yes ○No
Did you go to a hospital? ○Yes ○No (If no skip to signature)
Were you hospitalized over night? ○Yes ○No
Did you receive any stitches for any cuts at the hospital? ○Yes ○No
Were Xrays taken at the hospital? ○Yes ○No If yes, which areas? _____
What you were prescribed at the hospital: ☐Pain Medicine ☐Muscle Relaxors ☐Neck Brace
What was the name of the hospital? _____
How did you get to hospital? _____
Signature: _____ **Date:**_____

ABSHIRE CHIROPRACTIC

ROWDY C. ABSHIRE, D.C., B.S.R.T.

REVISED NECK OSWESTRY 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 **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.
- I can not 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.

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BSHIRE CHIROPRACTIC

ROWDY C. ABSHIRE, D.C., B.S.R.T.

REVISED LOW BACK 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 **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 moderately increasing
- ○ 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.

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