

## Auto Accident Forms

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Please mark your involvement in the Auto Accident:  Pedestrian  Driver  Passenger

What are your current symptoms?  Pain  Numbness  Stiffness  Weakness

Date of Accident \_\_\_\_\_

Patient was located:  Driver  Passenger-middle front  Passenger-right front

Passenger-left rear  Passenger- middle rear  Passenger –right rear

Patient Vehicle Type:  Compact  Mid-Size  Full-Size  SUV  Pick-Up  Motorcycle

Second Vehicle Type:  Compact  Mid-Size  Full-Size  SUV  Pick-Up  Motorcycle

Third Vehicle Type:  Compact  Mid-Size  Full-Size  SUV  Pick-Up  Motorcycle

Road Conditions:  Clear  Dark  Dry  Wet  Icy  Foggy

Road Type:  Asphalt  Concrete  Dirt  Gravel

Were you aware the accident was going to occur?  Yes  No

Were you wearing a seatbelt?  Yes  No

Did your airbag deploy?  Yes  No

What position was the head rest in?  Up  Middle  Down

Patient's Head Position:  Looking Straight Ahead  Left Level  Left Up  Left Down

Right Level  Right Up  Right Down  Looking Down  Looking Up

### Accident Details

Was your car breaking?  Yes  No Was your car moving?  Yes  No

If yes, how fast?(mph)  <5  6-10  11-15  16-20  21-30  31-40  41-50  51-60  61-70  >70

Was the second vehicle breaking?  Yes  No Was the second vehicle moving?  Yes  No

If yes, how fast? (mph)  <5  6-10  11-15  16-20  21-30  31-40  41-50  51-60  61-70  >70

Was the third vehicle breaking?  Yes  No Was the third vehicle moving?  Yes  No

If yes, how fast? (mph)  <5  6-10  11-15  16-20  21-30  31-40  41-50  51-60  61-70  >70

### Collision Details

First Impact:  Hit by other vehicle  Hit other vehicle  Hit by object  Hit object

Impact Location:  Front  Front-right  Front-left  Left  Right  Right-rear

Top  Rear  Left-rear

Second Impact:  Hit by other vehicle  Hit other vehicle  Hit by object  Hit object

Impact Location:  Front  Front-right  Front-left  Left  Right  Right-rear

Top  Rear  Left-rear

### Collision Results

The NDI is scored the same way as the Oswestry Disability Index

Using this system, a score of 10-28% (i.e. 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

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**Body was thrown:** Forward Backward Left Right Can't Remember

**Head Hit:** Airbag Front Windshield Rearview Mirror Steering Wheel Back of the front seat Side window/ door Another person's body Headrest

**Chest Hit:** Airbag Back of the front seat Side window/ door Dashboard Another person's body Steering Wheel

**Shoulders Hit:** Shoulder harness Side window/door Back of front seat Another person's body

**Knees Hit:** Steering wheel Dashboard Back of front seat Door panel Center console Another person's body

**Hips Hit:** Steering wheel Dashboard Back of front seat Door panel Center console Another person's body

### *Vehicle Damage*

**Patient Vehicle:** Totaled Significant Damage Light Damage No Damage

**Second Vehicle:** Totaled Significant Damage Light Damage No Damage

**Third Vehicle:** Totaled Significant Damage Light Damage No Damage

### *Hospitalized*

**Were you hospitalized?** No Yes If yes, please answer the questions below.

**When were you hospitalized?** Immediately Later same day Next day Date\_\_\_\_\_

**How were you transported to the hospital?** Ambulance Life flight Private transportation

**What did the hospital recommend?** No instructions See this clinic See DC See own doctor See orthopedist See neurologist Prescription medication

**Did you have any x-rays taken?** No Yes

If yes, what areas? \_\_\_\_\_

**Do you have an attorney?** No Yes

If so, please give us their contact information.

Name:\_\_\_\_\_ Street:\_\_\_\_\_

City:\_\_\_\_\_ State:\_\_\_\_\_ Zip:\_\_\_\_\_ Phone #:\_\_\_\_\_

**Do you have major medical insurance coverage on your car?** No Yes

Name of insurance company:\_\_\_\_\_ Zip\_\_\_\_\_ City\_\_\_\_\_ State\_\_\_\_\_

Street\_\_\_\_\_ Phone Number:\_\_\_\_\_

Adjuster's

Name:\_\_\_\_\_ Claim #:\_\_\_\_\_

**Does the other party involved have insurance coverage?** No Yes Name of insurance

company:\_\_\_\_\_ Zip\_\_\_\_\_ City\_\_\_\_\_ State\_\_\_\_\_ Street\_\_\_\_\_

Phone Number:\_\_\_\_\_ Adjuster's

Name:\_\_\_\_\_ Claim #:\_\_\_\_\_

## Auto Accident Forms

### Tell Us About You

**How were you feeling before the accident?** \_\_\_\_\_

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Please indicate which of the following were noticed after the accident. If they were noticed, were they noticed immediately, within a few hours, the next day, or later? Circle which side **L=Left, R=Right**, circle **L & R** if **both** sides were hurt.

<u>Symptom</u>		<u>Immediate</u>	<u>Few Hours</u>	<u>Next day</u>	<u>Later</u>
<input type="checkbox"/> Headache		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder Numb	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Arm Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Arm Numb	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Elbow Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Elbow Numb	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lower Arm Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lower Arm Numb	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wrist Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wrist Numb	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand Numb	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Back Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Middle Back Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Low Back Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip Numb	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Leg Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Leg Numb	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Knee Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Knee Numb	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lower Leg Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lower Leg Numb	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ankle Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<input type="checkbox"/> Ankle Numb	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot Pain	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot Numb	L / R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dizziness		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>Symptom</u>	<u>Immediate</u>	<u>Few Hours</u>	<u>Next day</u>	<u>Later</u>
<input type="checkbox"/> Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tired all the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Unable to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# Auto Accident Forms

## The Neck Disability Index

Score \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

This questionnaire has been designed to give the doctor information as to how your neck 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 one box that most closely describes your problem.

### **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 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, for example, on a table
- Pain prevents me from lifting heavy weights off the floor, 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 to, with no pain in my neck
- I can read as much as I want to, with slight pain in my neck
- I can read as much as I want to, 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

### **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 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 concentrating when I want to
- I have a great deal of difficulty 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 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 (5-8 hours 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 neck pain
- I am able to engage in most, but not all, of my usual recreational activities because of pain in my neck
- I am able to engage in few of my 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

# Auto Accident Forms

## Oswestry Disability Questionnaire

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Name: \_\_\_\_\_

Score: \_\_\_\_\_  
Date: \_\_\_\_\_

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but please just check one box that indicates the statement which most clearly describes your problem.

### **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 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 can manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, 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 me extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example, 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
- I cannot lift or carry anything

### **Section 4 – Walking**

- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 1 mile
- Pain prevents me from walking more than .5 miles
- Pain prevents me from walking more than .25 miles
- I can only walk using a walker or crutches
- I am in bed most of the time

### **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 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

### **Section 6 – Standing**

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

### **Section 7 – Sleeping**

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours of sleep
- Because of pain I have less than 4 hours of sleep
- Because of pain I have less than 2 hours of sleep
- Pain prevents me from sleeping at all

### **Section 8 – Sex Life (If applicable)**

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

### **Section 9 – Social Life**

- My social life is normal and gives me no extra 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, for example, sports.
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

### **Section 10 – Travel**

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over 2 hours
- Pain restricts me to journeys of less than 1 hour
- Pain restricts me to short, necessary journeys under 30 minutes
- Pain prevents me from travelling except to receive treatment

