What does the pain / dysfunction keep you from doing
(what did you do before this problem that you cannot do now)

☐ Bending ☐ Climb stairs ☐ Driving ☐ Exercise ☐ Doing Dishes ☐ Doing Laundry

☐ Vacuum ☐ Sweep ☐ Mop ☐ Grip/Grasp ☐ Lifting ☐ Reaching

☐ Sitting ☐ Sleep ☐ Standing ☐ Walking ☐ Work ☐ Yard work

Can You Dress Yourself? ☐ Yes ☐ Yes, but it takes time ☐ No, I need help

IF YOUR PROBLEM IS DUE TO A MOTOR VEHICLE CRASH OR A PERSONAL INJURY, PLEASE FILL OUT THIS NEXT SECTION.

1) Date of Crash / injury:_____ Time of day:_____ a.m. / p.m. Location:_____

2) Was a police report made? Yes No Was An Injury Report made? Yes No

3) Who else was in the vehicle?_____ Were They Injured? Yes No

4) **Your ins.co.**: _____ Policy #:_____ Claim #:_____

Adjuster's name and Phone #: _____ Address:_____

5) **Other party's name and ins. co.**: _____ policy #:_____

Address: _____ City: _____ State: _____ Zip: _____

Attorney Name: _____ Phone: _____

6) Address:_____ City: _____ State: _____ Zip: _____

7) Were there any witnesses? ☐ Yes ☐ No Name(s): _____

8) Because of this Injury, have you lost any work? ☐ Yes ☐ No Last Date Worked: ___/___/___

9) Date returned to regular work: ___/___/___ Are you working now? ☐ Yes ☐ No

10) Because of this Injury, were you unconscious?
☐ No ☐ Not Sure, how long ☐ A few seconds ☐ A few minutes ☐ An hour ☐ A few hours

11) After the Injury, did you feel: (check as many as apply)
☐ Stunned ☐ Frightened ☐ Confused ☐ Dazed ☐ Dizzy ☐ Shocked ☐ Shaken ☐ Nauseous

12) Did you receive medical aid at the Injury site? ☐ Yes ☐ No

13) Where did you go right after the Injury?
☐ Hospital ☐ Urgent care ☐ Home ☐ Work ☐ Family physician ☐ To this office

14) How did you get there? ☐ Ambulance ☐ Drove myself ☐ Someone drove me ☐ Walked

15) Did your symptoms develop:
☐ Immediately ☐ Hours later ☐ Next day ☐ Over the first few days ☐ Over the next few weeks

Patient Signature: _____ Date: _____