AUTO ACCIDENT INTAKE FORM

Name: Last____________________ First_____________________ Middle__________________ Birthdate___/___/_______

Address___________________________________ City______________________ State____________ Zip_____________

Phone Number (cell)_____________________ (home)______________________ Today's Date ___/___/_______

Email___________________________________ Occupation_______________________ Employer_______________________

Emergency Contact Name__________________________ Phone Number_____________________ Relation_________________

Who may we thank for referring you to our office? ____

Who is your primary care physician? ____ Phone Number____________________

Date of last physical/exam: ____________________________

Date of accident_______________ Time of accident________ am / pm ☐ **Daylight** ☐ **Dawn** ☐ **Dusk** ☐ **Dark**

Road conditions at the time of accident ☐ **Wet** ☐ **Dry** ☐ **Paved** ☐ **Dirt** ☐ **Other**______________________

Was this accident on the job? ☐ **Yes** ☐ **No** If yes, were you in a company vehicle? ☐ **Yes** ☐ **No**

Where were you seated in the vehicle? ☐ **Driver** ☐ **Passenger** ☐ **Rear-seat** ☐ **Other**__________________

Were you aware of the approaching collision prior to impact or were you surprised? ☐ **Aware** ☐ **Surprised**

Did you lose consciousness upon impact? ☐ **Yes** ☐ **No**

Did you experience a flash of light or an 'explosion' in your head? ☐ **Yes** ☐ **No**

Did the police come to the scene of the accident? ☐ **Yes** ☐ **No** If yes, was there a report written? ☐ **Yes** ☐ **No**

Were you wearing a seatbelt? ☐ **Yes** ☐ **No** If yes, did you receive any injury or bruising from the seatbelt? ☐ **Yes** ☐ **No**

Did your head hit the headrest during the accident? ☐ **Yes** ☐ **No**

Was the position of the headrest altered? ☐ **Yes** ☐ **No**

Was the seat adjustment altered by the accident? ☐ **Yes** ☐ **No**

Was the seat broken by the accident? ☐ **Yes** ☐ **No**

Did the airbag deploy? ☐ **Yes** ☐ **No** If yes, did it strike you? ☐ **Yes** ☐ **No** If yes, where? ______________

Which way was your head pointing at the time of impact? ☐ **Straight** ☐ **Down** ☐ **Right** ☐ **Left**

Which way was your body pointing at the time of impact? ☐ **Straight** ☐ **Right** ☐ **Left**

Where were your hands? ☐ **One on the wheel** ☐ **Both on the wheel** ☐ **Other** ______________________

Were you wearing a hat or glasses at the time of impact? ☐ **Yes** ☐ **No** If yes, were they still on after impact? ☐ **Yes** ☐ **No**

Did you go to the hospital? ☐ **Yes** ☐ **No** If yes, when? ☐ **Immediately** ☐ ___**hours later** ☐ ___**days later**

Which hospital? ____

How did you get to the hospital? _______________________ How long did you stay at the hospital? ______________________

Continued on next page…

What did the hospital do for your injuries? (collars, splints, x-rays, medication, surgery, etc.) ________________________________

____

What areas were x-rayed? ________________________ What was their diagnosis? ____

What did they recommend for follow-up care? ____

Was any other doctor consulted after your accident? ☐ **Yes** ☐ **No** If yes, please complete information below:

Dr. _________________________ Specialty:________________________ Date first seen:____________________

Type of treatment:_____________________________ Treatment frequency:___________________________

Are you still receiving treatment? _________________________

YOUR VEHICLE

Please list the year, make, and model of the car you were in: **Year**_________ **Make**______________ **Model**________________

Was your car stopped at the time of impact? ☐ **Yes** ☐ **No**

If yes, was the driver's foot on the brake? ☐ **Yes** ☐ **No** If no, estimate the speed of the vehicle you were in: ______ mph

If your vehicle was moving at the time of impact, was it: ☐ **Slowing down** ☐ **Gaining speed** ☐ **Steady speed**

OTHER VEHICLE

Please list the year, make, and model of the other car: **Year**_________ **Make**_______________ **Model**_________________

Was the other vehicle moving at the time of impact? ☐ **Yes** ☐ **No**

If yes, what was the approximate sped of the vehicle: ______ mph

At the time of impact, the other car was: ☐ **Slowing down** ☐ **Gaining speed** ☐ **Steady speed**

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in: ____

Name of auto insurance: ___________________________________

Policy #: _______________________ Claim #: ______________________________

Auto insurance phone number: ________________________ Name of insurance adjuster: __________________________

Driver of the ***other*** automobile: ______________________________________

Name of their auto insurance: ________________________________

Policy #: _______________________ Claim #: ______________________________

Auto insurance phone number: ________________________ Name of insurance adjuster: ___________________________

Have you retained an attorney? ☐ **Yes** ☐ **No**

If yes, what is their name and phone number? ____

LIFESTYLE INFORMATION

Do you smoke? ☐ **Yes** ☐ **No** If yes, how many packs per week? ______

Continued on next page…

Do you consume alcohol? ☐ **Yes** ☐ **No** If yes, how many drinks per week? _______

Do you consume caffeine? ☐ **Yes** ☐ **No** If yes, how many drinks per day? _______

Do you exercise? ☐ **Yes** ☐ **No** If yes, how many times per week? ________ What type? ________________________

Do you have a high stress level? ☐ **Yes** ☐ **No** If yes, please list reasons: ____

Please list any medications, vitamins, or supplements you are currently taking:

Name:__________________________ Frequency:_________ Dosage:________ What is this for?_____________________

Name:__________________________ Frequency:_________ Dosage:________ What is this for?_____________________

Name:__________________________ Frequency:_________ Dosage:________ What is this for?_____________________

Name:__________________________ Frequency:_________ Dosage:________ What is this for?_____________________

OCCUPATIONAL INFORMATION

Job involves: ☐ **Sitting** ☐ **Standing** How long? ________ ☐ **Lifting** How much? _______ lbs.

☐ **Bending** ☐ **Twisting** ☐ **Turning** ☐ **Stooping**

Physical activity at work: ☐ **Sedentary** ☐ **Light, manual labor** ☐ **Manual labor** ☐ **Intense, manual labor**

Have you missed any time from work due to the accident? ☐ **Yes** ☐ **No** If yes, how many days? ________

Dates of work missed: __________________________

Are your work activities restricted because of the accident? ☐ **Yes** ☐ **No** If yes, please explain: _________________________

____

Do any of your work activities aggravate your current complaints? ☐ **Yes** ☐ **No** If yes, please explain: _________________

____

CURRENT COMPLAINTS

Check any of the symptoms below you have noticed since the accident:

- ☐ Headaches/Migraines
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain
- ☐ Depression
- ☐ Buzzing in Ears
- ☐ Arm/Leg Pain
- ☐ Jaw Pain/Clicking
- ☐ Dizziness
- ☐ Fatigue
- ☐ Loss of Memory
- ☐ Cold Hands/Feet
- ☐ Numbness/Tingling
- ☐ Loss of Smell
- ☐ Irritability
- ☐ Digestive Problems
- ☐ Joint Pain/Stiffness
- ☐ Menstrual Problems
- ☐ Pinched Nerve
- ☐ Loss of Sleep
- ☐ Loss of Balance
- ☐ Chest Pain
- ☐ Sensitivity to Light
- ☐ Fever
- ☐ Nervousness
- ☐ Other: ________________
- ☐ Vision Problems
- ☐ Urinary Problems
- ☐ Sleeping Problems
- ☐ Paralysis
- ☐ Tension
- ☐ Fainting
- ☐ Pins/Needles Feeling
- ☐ Upset Stomach
- ☐ Difficulty Swallowing
- ☐ Sciatica
- ☐ Sinus Pain
- ☐ Sore Muscles
- ☐ Head Feels Too Heavy

At the time of the accident, did you become or experience any of the following?

- ☐ Disoriented
- ☐ Dizzy
- ☐ Confused
- ☐ Nauseated

Continued on next page…

☐ Blurred Vision ☐ Lightheaded
☐ Loss of Balance ☐ Ringing/Buzzing in Ears

Do you still have any of these symptoms? ☐**Yes** ☐**No** If yes, which ones? ______________________________________

____

SPECIFIC AREAS OF COMPLAINT

1. Body Part: ____

   Date symptom first appeared: _________________

   How often do you experience these symptoms?

   ☐**Constant** 100% ☐**Frequent** 75% ☐**Intermittent** 50% ☐**Occasional** 25% ☐**Rare** 10%

   What makes these symptoms increase? ____

   What makes these symptoms decrease? ____

   Types of pain? ☐**Sharp** ☐**Dull** ☐**Aching** ☐**Burning** ☐**Throbbing** ☐**Numbness**

   ☐**Other:**_____________________

   Please rate the intensity of your symptoms (0 being no pain, 10 being extreme)

   0 ◆ 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ◆ 6 ◆ 7 ◆ 8 ◆ 9 ◆ 10

   If the pain radiates, where does it radiate to? ____

2. Body Part: ____

   Date symptom first appeared: _________________

   How often do you experience these symptoms?

   ☐**Constant** 100% ☐**Frequent** 75% ☐**Intermittent** 50% ☐**Occasional** 25% ☐**Rare** 10%

   What makes these symptoms increase? ____

   What makes these symptoms decrease? ____

   Types of pain? ☐**Sharp** ☐**Dull** ☐**Aching** ☐**Burning** ☐**Throbbing** ☐**Numbness**

   ☐**Other:**_____________________

   Please rate the intensity of your symptoms (0 being no pain, 10 being extreme)

   0 ◆ 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ◆ 6 ◆ 7 ◆ 8 ◆ 9 ◆ 10

   If the pain radiates, where does it radiate to? ____

3. Body Part: ____

   Date symptom first appeared: _________________

   How often do you experience these symptoms?

   ☐**Constant** 100% ☐**Frequent** 75% ☐**Intermittent** 50% ☐**Occasional** 25% ☐**Rare** 10%

   What makes these symptoms increase? ____

   What makes these symptoms decrease? ____

   Types of pain? ☐**Sharp** ☐**Dull** ☐**Aching** ☐**Burning** ☐**Throbbing** ☐**Numbness**

   ☐**Other:**_____________________

   Please rate the intensity of your symptoms (0 being no pain, 10 being extreme)

   0 ◆ 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ◆ 6 ◆ 7 ◆ 8 ◆ 9 ◆ 10

   If the pain radiates, where does it radiate to? ____

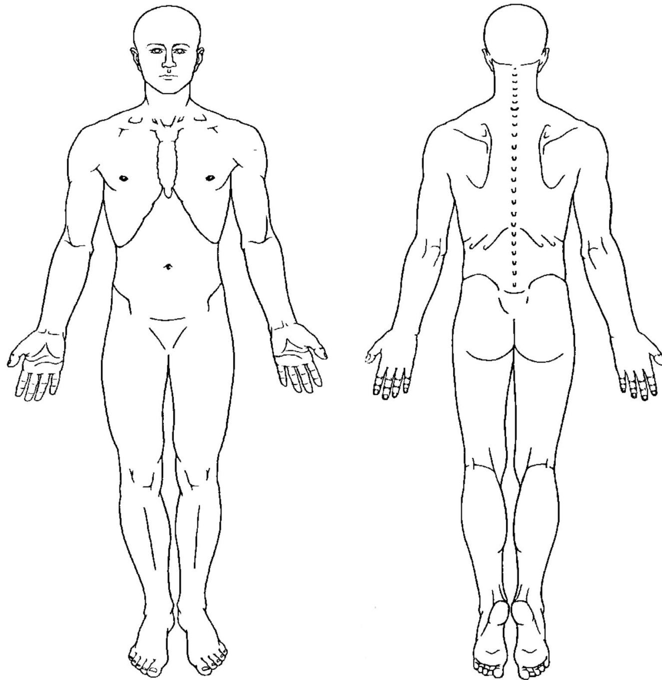
Continued on next page…

Other body parts affected (shoulders, knees, head, wrists, etc.)? ____

Any other additional information: ____

____

____

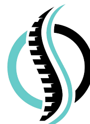


Circle areas of pain/symptoms on the body diagram.

They should match the regions of pain listed on the prior page.

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

____ Patient Signature _______________ Date



ORLANDO
SPINE STUDIO

Dr. James M Bowles
Board Certified Chiropractic Physician
11500 Univeristy Blvd, Ste 103, Orlando FL, 32773
P: 407 658 6500 | F: 407 277 2690

Dr. James Bowles

Chiropractic Physician

11500 University Blvd, Ste 103

Orlando FL, 32817

P 407-658-6500 | F 407-277-2690

Assignment of Insurance Benefits

The undersigned hereby assigns the rights and benefits of their insurance under the applicable automobile insurance policy held with:

____,

for any services provided and/or charges incurred by East Colonial Chiropractic, D.C., P.A. dba Orlando Spine Studio.

Date: ____________________

Patient Name: ______________________________________

Patient Signature: ____

Informed Consent to Procedures

I hereby request and consent to the performance of chiropractic manipulation or adjustments and other chiropractic procedures, including various modes of physical therapy or physical medicine procedures, and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by the chiropractic physician named below and/or other licensed chiropractors who now or in the future treat me while employed by, working or associated with or serving as backup for the chiropractic physician named below.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic manipulations or adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I understand all procedures being performed at this facility are deemed safe and supported by clinical research and evidence but, the risk must be disclosed even if an extremely small percentage of patients report adverse effects. I do not expect the doctor to be able to anticipate and explain all possible risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition.

Patient Signature: ____

Date: ____

To be completed by the patient's representative, if necessary, e.g., if patient is a minor or physically or otherwise legally incapacitated.

Signature of Patient's Representative: ______________________________________

Date: ____

Orlando Spine Studio
11500 University Blvd, Ste 103
Orlando FL, 32817

Dr. James M Bowles
Chiropractic Physician

Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal care, we request that you follow our guidelines regarding missed and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours' notice to reschedule your appointment. This will also enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute everyone loses out; you, the doctor and the other patients that would like to have utilized your appointment time.

Our office does charge a $25 fee for broken or canceled appointments with less than 24-hour notice or a no show without notice. We do realize last-minute emergencies arise, so this fee will be assessed on a case-by-case basis. Please realize how important it is to keep your reserved time.

You may notify us via phone call, text, or email before the 24-hour deadline to be considered in good standing with our policy. Thank you for your consideration of our policies and for the opportunity to serve you.

Please sign acknowledging that you have read our above statement and you understand our right to enforce the cancellation fee if the policy is broken.

Name (print): ___________________________________

Signature: ______________________________________

Date: ____________________

ORLANDO SPINE STUDIO

NECK Pain and Disability Questionnaire

Rate the severity of your pain by circling one number: (No Pain) 0…1…2…3…4…5…6…7…8…9…10 (Excruciating Pain)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Read through each section and check only ONE line that applies to you. You may find that two of the statements in a section relate to you, but please just check ONE line that best describes your current predicament.

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.
___ I am slow and careful because it is painful for me to look after myself.
___ I need some help but manage most of my personal care.
___ I need help every day in most aspects of care.
___ I do not get dressed, I wash with difficulty and stay in bed.

Section 3– Lifting
___ I can lift heavy weight without extra pain.
___ I can lift heavy weight but it causes extra pain.
___ I cannot lift heavy weight off the floor, but I can manage if they are conveniently positioned like on a table.
___ I cannot lift heavy weight, but I can manage light to medium weights if they are conveniently positioned.
___ I cannot lift any weight due to neck pain.

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 neck pain.
___ I can read as much as I want to with moderate neck pain.
___ I cannot read as much as I want to due to moderate neck pain.
___ I can hardly read at all because of severe neck pain.

Section 5– Headaches
___ I have no headaches at all.
___ I have slight headaches that occur infrequently.
___ I have moderate headaches that occur infrequently.
___ I have frequent moderate headaches.
___ I have frequent severe headaches.
___ I have severe 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 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 barely do any work at all.
___ I cannot 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 neck pain.
___ I can drive my car as long as I want with moderate neck pain.
___ I cannot drive my car as long as I want.
___ I can hardly drive at all because of severe neck pain.
___ I cannot 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 hour sleepless)
___ My sleep is moderately disturbed (2 to 3 hours sleepless)
___ My sleep is greatly disturbed (4 to 5 hours sleepless)
___ My sleep is completely disturbed (6 to 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.
___ I am able to engage in a few of my usual recreation activities.
___ I can hardly do any recreation activities.
___ I cannot do any recreation activities due to neck pain.

______________________________ Patient Name (Print)

______________________________ Patient Signature

______________ Date

FOR OFFICE USE ONLY:

________ x 2 = ________

Total Points | Disability Percentage

______________________________ Rating Scale

Patient's Name____ Number____________ Date___________________

LOW BACK 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 in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

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, 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 lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

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 almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = ____________ %ADL

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 extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – 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, e.g. dancing.
☐ 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 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree 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 improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204