

Patient Name: _____ Today's Date: ___/___/___

MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Why did you make an appointment to see the doctor?

- _____ Evaluation
- _____ Surgical opinion
- _____ Reassurance
- _____ Other
- _____ Specify: _____

What was the date of injury: _____

What part of your spine/back hurts?

- _____ Cervical (neck)
- _____ Thoracic (upper back)
- _____ Thoracolumbar (mid back region)
- _____ Lumbar (low back)
- _____ Sacroiliac (tailbone)

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Please explain how the current injury occurred:

Did you have any spinal discomfort/symptoms **before** your current injury? If yes, please specify length of time.

Yes No

	Numbness/Pain/Weakness	Length of Time
___ Neck symptoms		_____
___ Symptoms in both arms		_____
___ Right arm symptoms	_____	_____
___ Left arm symptoms	_____	_____
___ Headaches		_____
___ Visual changes		_____
___ Loss of consciousness		_____
___ Chest symptoms		_____
___ Thoracic symptoms		_____
___ Low back symptoms		_____
___ Symptoms in both buttocks	_____	_____
___ Right buttock symptoms	_____	_____
___ Left buttock symptoms	_____	_____
___ Symptoms in both legs	_____	_____
___ Right leg symptoms	_____	_____
___ Left leg symptoms	_____	_____
___ Other	_____	_____
Specify: _____		

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Page Three

What are your spinal complaints since your current injury? Please specify length of time.

	Numbness/Pain/Weakness	Length of Time
___ Neck symptoms		_____
___ Symptoms in both arms		_____
___ Right arm symptoms	_____	_____
___ Left arm symptoms	_____	_____
___ Headaches	_____	_____
___ Visual changes		_____
___ Loss of consciousness		_____
___ Chest symptoms		_____
___ Thoracic symptoms		_____
___ Low back symptoms		_____
___ Symptoms in both buttocks		_____
___ Right buttock symptoms	_____	_____
___ Left buttock symptoms	_____	_____
___ Symptoms in both legs	_____	_____
___ Right leg symptoms	_____	_____
___ Left leg symptoms	_____	_____
___ Other	_____	_____
Specify: _____		

Did the pain develop immediately, or was the pain delayed? If delayed, please specify length of time _____.

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NECK TO ARM PAIN RATIO: (Fill out only if you have neck pain.)

	Yes	No
Is neck pain greater than arm pain?	<input type="checkbox"/>	<input type="checkbox"/>
Is arm pain greater than neck pain?	<input type="checkbox"/>	<input type="checkbox"/>

Please circle one of the ratios listed below which **best** describes the amount of pain you feel in your neck as compared to your arm.

Neck Pain Compared to Arm Pain:

- 100% neck pain to 0% arm pain
- 90% neck pain to 10% arm pain
- 80% neck pain to 20% arm pain
- 70% neck pain to 30% arm pain
- 60% neck pain to 40% arm pain
- 50% neck pain to 50% arm pain
- 40% neck pain to 60% arm pain
- 30% neck pain to 70% arm pain
- 20% neck pain to 80% arm pain
- 10% neck pain to 90% arm pain
- 0% neck pain to 100% arm pain

BACK TO LEG PAIN RATIO: (Fill out only if you have back pain.)

	Yes	No
Is back pain greater than leg pain?	<input type="checkbox"/>	<input type="checkbox"/>
Is leg pain greater than back pain?	<input type="checkbox"/>	<input type="checkbox"/>

Please circle one of the ratios listed below which **best** describes the amount of pain you feel in your back as compared to your leg.

Back Pain Compared to Leg Pain:

- 100% back pain to 0% leg pain
- 90% back pain to 10% leg pain
- 80% back pain to 20% leg pain
- 70% back pain to 30% leg pain
- 60% back pain to 40% leg pain
- 50% back pain to 50% leg pain
- 40% back pain to 60% leg pain
- 30% back pain to 70% leg pain
- 20% back pain to 80% leg pain
- 10% back pain to 90% leg pain
- 0% back pain to 100% leg pain

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Which health professionals have you seen for your current injury? Please list their names, whether or not they were seen within 24 hours of the injury, and the treatment and medications prescribed.

___ Company doctor _____
Treatment/Results _____

Medicines/Results _____

___ Chiropractor _____
Treatment/Results _____

Medicines/Results _____

___ Emergency room doctor _____
Treatment/Results _____

Medicines/Results _____

___ Family doctor _____
Treatment/Results _____

Medicines/Results _____

___ Internist _____
Treatment/Results _____

Medicines/Results _____

___ Neurosurgeon _____
Treatment/Results _____

Medicines/Results _____

___ Neurologist _____
Treatment/Results _____

Medicines/Results _____

___ Orthopedist _____
Treatment/Results _____

Medicines/Results _____

___ Other _____
Treatment/Results _____

Medicines/Results _____

___ Other _____
Treatment/Results _____

Medicines/Results _____

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Please list any medications you are taking for your current injury.

Medication	Prescribed By	Date Initiated	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What treatment have you received for your current injury? Please specify length of time and results.

	Length of Time	Results
_____ Acupressure	_____	_____
_____ Acupuncture	_____	_____
_____ Biofeedback	_____	_____
_____ Brace	_____	_____
_____ Chiropractor	_____	_____
_____ Hypnosis	_____	_____
_____ Occupational therapy	_____	_____
_____ Physical therapy	_____	_____
_____ Other	_____	_____
_____ Specify _____	_____	_____

Please list any x-rays/tests performed for your current injury.

X-ray/Test	Area of body	Date	Facility/Hospital	City/State
_____ Bone scan	_____	_____	_____	_____
_____ CT scan	_____	_____	_____	_____
_____ Discography	_____	_____	_____	_____
_____ Doppler studies	_____	_____	_____	_____
_____ EMG/NCV	_____	_____	_____	_____
_____ Facet block injection	_____	_____	_____	_____
_____ Gallium scan	_____	_____	_____	_____
_____ Indium scan	_____	_____	_____	_____
_____ MRI	_____	_____	_____	_____
_____ Myelogram	_____	_____	_____	_____
_____ Nerve root injection	_____	_____	_____	_____
_____ Plain x-rays	_____	_____	_____	_____
_____ Other	_____	_____	_____	_____

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With these activities, is your pain better, is it worse, is it unchanged?

	Better	Worse	Unchanged
_____ With cough or sneeze	_____	_____	_____
_____ Sitting down at a table	_____	_____	_____
_____ Sitting in an automobile	_____	_____	_____
_____ Bending forward to brush teeth	_____	_____	_____
_____ Walking a short distance	_____	_____	_____
_____ Lying flat on back	_____	_____	_____
_____ Lying flat on stomach	_____	_____	_____
_____ Lying on side with knees bent	_____	_____	_____
_____ Upon awakening in the morning	_____	_____	_____
_____ Mid-morning	_____	_____	_____
_____ Middle of the night	_____	_____	_____

PLEASE RESPOND TO THE FOLLOWING QUESTIONNAIRE ABOUT YOUR ABILITY TO FUNCTION. CIRCLE THE **BEST** ANSWER.

PAIN INTENSITY

1. Tolerate pain without pain medication
2. Pain, but do not take pain killers
3. Pain killers give complete relief
4. Pain killers give moderate relief
5. Pain killers give very little relief
6. Pain killers have no effect on pain, therefore, do not use

PERSONAL CARE

1. Look after myself normally without causing extra pain
2. Look after myself with some extra pain
3. Painful, but I do it slowly and carefully
4. I need some help but manage most of my personal care
5. I need help every day in most aspects of my care
6. I do not get dressed and stay in bed

LIFTING

1. I can lift any weight without problem
2. I lift, but it causes spinal pain
3. I cannot lift over 20 lbs
4. I cannot lift over 10 lbs
5. I cannot lift without pain

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WALKING

1. Pain does not prevent me from walking any distance
2. Pain prevents me from walking more than 1 mile
3. Pain prevents me from walking more than 1/2 mile
4. Pain prevents me from walking more than 1/4 mile
5. Can only walk using a cane or crutches
6. Restricted to bed and have to crawl to the toilet

SITTING

1. Can sit in any chair as long as I like
2. Can only sit in my favorite chair as long as I like
3. Cannot sit more than 1 hour
4. Cannot sit more than 1/2 hour
5. Cannot sit more than 10 minutes
6. Cannot sit at all

WORKING

1. Work 8 hours per day without pain
2. Work 8 hours, but it causes pain
3. Cannot work 8 hours, but can work 4 hours
4. Cannot work 4 hour without pain
5. Cannot work

SLEEPING

1. Pain does not prevent me from sleeping
2. Sleep only with medication
3. Sleep less than 6 hours with medication
4. Sleep less than 4 hours with medication
5. Sleep less than 2 hours with medication
6. Pain prevents me from sleeping at all

SEX LIFE

1. Normal and causes no extra pain
2. Normal, but causes some extra pain
3. Nearly normal, but is very painful
4. Severely restricted by pain
5. Nearly absent because of pain
6. Pain prevents any sex life at all
7. No response

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SOCIAL LIFE

1. Normal with no pain
2. Normal, but increases the pain
3. Limits my more energetic interests, such as dancing
4. Limits my social life and I do not go out often
5. Has restricted my social life to my home
6. I have no social life because of my pain

TRAVELING

1. Can travel anywhere without extra pain
2. Can travel anywhere with some pain
3. Pain is bad but manage journey over 2 hours
4. Pain restricts journeys to less than 1 hour
5. Pain restricts to necessary journeys under 30 minutes
6. Pain prevents any travel except to doctor/hospital

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If this injury is due to a motor vehicle accident, please answer the following questions.

Where did the accident occur? _____

Date of accident _____

Time of accident _____

Type of vehicles involved

- Car
- Pickup Truck
- 18-wheeler
- Motorcycle

Vehicle in which you were a passenger/driver

- Car
- Pickup Truck
- 18-wheeler
- Motorcycle

Number of vehicles involved, circle one 1 2 3 4 5 6 7 8 9 10

Were you the

- Driver
- Passenger (front seat)
- Passenger (back seat)
- Cyclist
- Pedestrian

Were you wearing a seat belt? Yes No

Was an air bag involved? Yes No

Accident occurred

- Daytime
- Dusk
- Nighttime

Weather was

- Clear
- Foggy
- Rainy
- Ice/Snow
- Dry

How fast were you going? _____

How fast was the other vehicle going? _____

Your vehicle was hit

- Rear-end
- Head-on
- Passenger side
- Driver side

Did your vehicle roll? Yes No

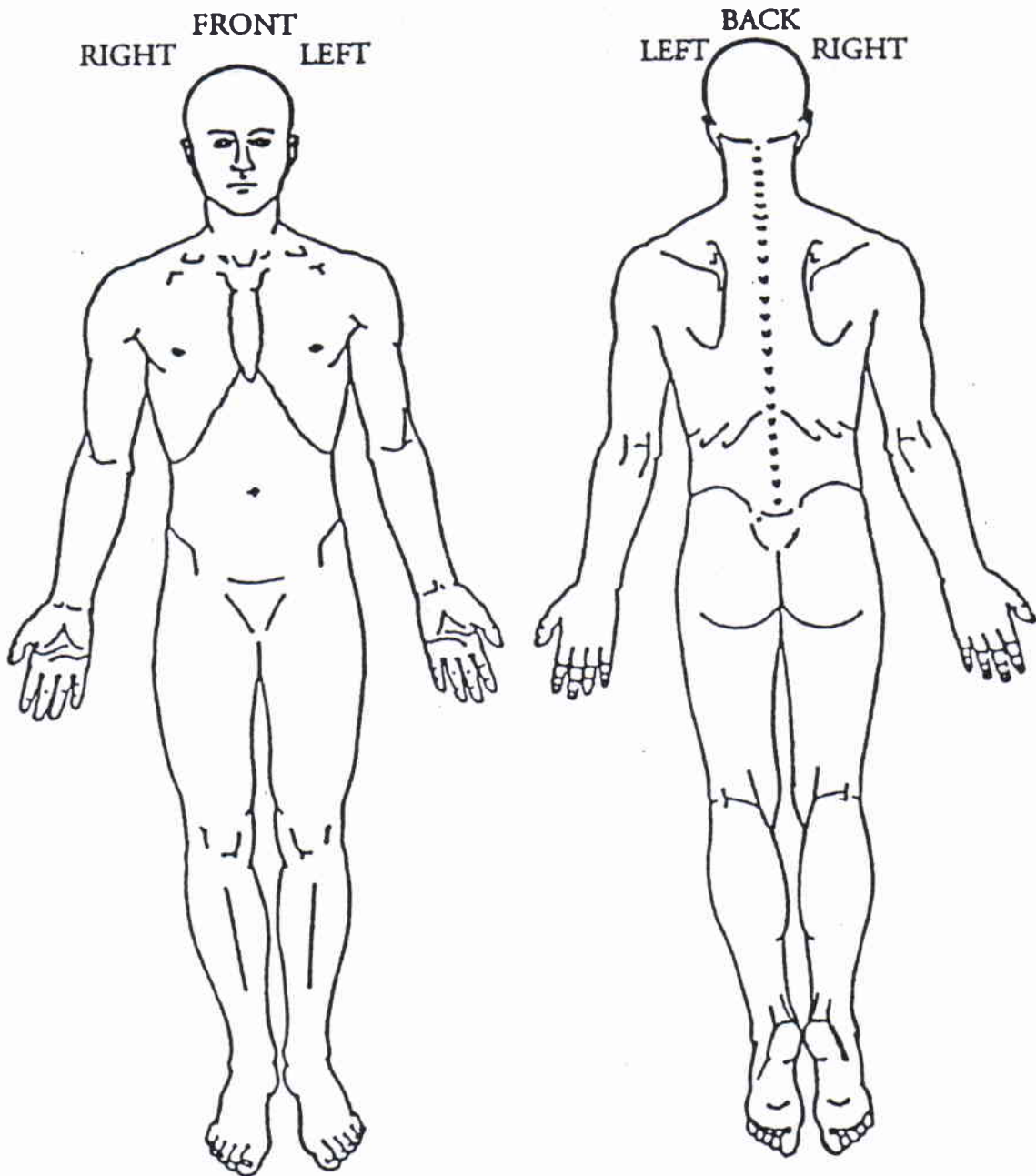
Were you drinking? Yes No

If you were a passenger, was your driver drinking? Yes No

Was the driver of the other vehicle drinking? Yes No

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness == == Pins & Needles oooo Burning xxxxx
 Stabbing //// Chronic Ache zzzz



ESTIMATE THE SEVERITY OF YOUR PAIN (CHOOSE ONE NUMBER)

0 No Pain 1 Mild Pain 2-3 Moderate Pain 4-5 Moderate to Severe Pain 6-7 Severe Pain

8-9 Intensely Severe Pain 10 Most Severe Pain PATIENT PLEASE INITIAL _____