SPINAL HEALTH & REHAB CENTER

Providing safe, state-of-the-art, non invasive spinal care since 1989

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Vax-D Non-Surgical Spinal Decompression
Medical Pain Management/Physical Medicine

AUTO ACCIDENT/PERSONAL INJURY QUESTIONNAIRE

Name _____ DOB ___/___/___ Today's Date ___/___/___

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

SS# _____ Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Sep.

Are you experiencing any of the following since the accident? (please check)

☐ Neck pain/stiffness ☐ Shoulder pain ☐ Headaches ☐ Upper back pain

☐ Lower back pain ☐ Fatigue ☐ Anxiety ☐ Numbness/weakness of the upper/lower extremities

☐ Dizziness ☐ Difficulty sleeping ☐ Visual disturbances ☐ Nausea/vomiting

☐ Difficulty concentrating ☐ Depression ☐ Other _____

INJURY HISTORY

Date and time accident occurred: DATE ___/___/___ TIME _____

Location _____ Who did you report the accident to? _____

Was a police report made? ☐ YES ☐ NO

Please explain in detail how this accident occurred: _____

_____

_____

If this was an auto accident:

You were struck from: ☐ Front ☐ Behind ☐ Left side ☐ Right side

You were: ☐ Driver ☐ Front seat passenger ☐ Rear seat passenger ☐ Motorcycle operator

☐ Motorcycle passenger ☐ Other _____

Estimated damage to your vehicle: ☐ None ☐ Minimal ☐ Moderate ☐ Major

AFTER THE ACCIDENT

Where were you taken after the accident? _____

How were you transported from the scene of the accident? _____

Have you treated with any other doctor(s) since the accident? _____

If yes, please provide names and dates seen: _____

Were x-rays taken? ☐ YES ☐ NO

Please describe your job activities: _____

Have you lost any time from work since the accident? ☐ YES ☐ NO

If YES, what was the first day you were unable to work? ____/____/____

Have you returned to work? ☐ YES ☐ NO If YES, when? ____/____/____

Are your work activities restricted as a result of the accident? ☐ YES ☐ NO

If YES, please explain: _____

_____

Past Medical History:

_____

_____

_____

Past Personal Injuries? ☐ YES ☐ NO (If YES, please give dates and details)

_____

_____

Past Worker's Comp Injuries? ☐ YES ☐ NO (If YES, please give dates and details)

_____

_____

Sports or other injuries to head, neck, or back:

_____

_____

Current Medical History

Do you use a heel lift, orthotic, or arch support? ☐ YES ☐ NO

Females: Are you pregnant or think you may be? ☐ YES ☐ NO

Date of first day of last menstrual period: ____/____/____

Current health problems: ☐ None

_____

_____

Current medications taken: ☐ None

_____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered.

_____ _____

Patient Signature Date