Jonker Chiropractic, SC
1620 London Rd
Duluth, MN 55812

Personal Injury Questionnaire

Today's Date______________ Date of Accident______________

PATIENT DATA

First Name ______________ Middle Initial ______ Last Name ______________

Age _______ Date of Birth______________ Referred By ______________

CONTACT INFORMATION

Street Address ______________ City ______________ State __________ Zip ______________

Home # (_____)______________ Work # (_____)______________ Cell # (_____)______________

E-mail ______________________________

THESE SECTIONS MUST BE FILLED OUT COMPLETELY IN ORDER TO PROCESS YOUR CLAIM!!

Your Auto Insurance Co.: ______________________ Claim #:______________

Agent's Name: ______________________ Agent's Phone #:______________

Have you retained an attorney? ☐ No ☐ Yes Name: ______________

Attorney's Phone # :______________________(Please supply us with a business card if possible)

Were there any witnesses? ☐ No ☐ Yes Names:______________

Were the police notified? ☐ No ☐ Yes **COPY OF ACCIDENT REPORT**

COPY OF PRIVATE *HEALTH* INSURANCE CARD REQUIRED

Your Health Insurance Company: ______________________

Insured's Name______________________ Policy Number:______________

Health Insurance Co. Phone #:______________________ Group #:______________

Name of Driver of other vehicle: ______________________

Auto Insurance Co.:______________________ Claim #: ______________

Adjuster's Name: ______________________ Phone #: ______________

The pages to follow are very important! Please take your time in sorting out the details and answer all questions as completely as possible, thank you.

AUTO ACCIDENT INFORMATION

1. Were you the: ☐Driver ☐Front Passenger ☐Rear Passenger
2. Make and model of the vehicle you were occupying:____________________
3. If traffic violation was issued, to whom was is issued?____________________
4. Did the police come to the accident site? ☐Yes ☐No
5. Was a police report filed? ☐Yes ☐No
6. Were there any witnesses? ☐Yes ☐No
7. In relation to the base of your skull, where was the headrest? ☐Above ☐Below ☐At base of skull
8. What did your vehicle impact? ☐Another vehicle ☐Other____________________
9. Did any part of your body strike anything in the vehicle? ☐Yes ☐No
   If yes, please describe:____________________

NATURE OF ACCIDENT

1. Time of Day:__________ ☐AM ☐ PM City:__________
2. # of people in your vehicle:__________ # in other vehicle:__________
3. Road Conditions at the time of accident: ☐Wet ☐Dry ☐Icy ☐Other, explain:__________
4. Direction you were heading: ☐North ☐South ☐East ☐West Name of Street:__________
5. Other car direction: ☐North ☐South ☐East ☐West Name of Street:__________
6. Were you struck from: ☐Behind ☐Front ☐Left Side ☐Right Side
7. Were you wearing a seatbelt: ☐Yes ☐No If yes: ☐Lap ☐Shoulder belt ☐Both
   Any bruising of soreness from belt: ☐Yes ☐No Explain:__________
8. Airbags Activated: ☐Yes ☐No
9. Head position at time of impact: ☐Facing forward ☐Head Turned Right ☐Head Turned Left
10. Were you knocked unconscious: ☐Yes ☐No If yes, for how long:__________
11. Were you aware of approaching impact: ☐Yes ☐No
    If yes, did you brace for impact: ☐Yes ☐No If yes, how:__________
12. Was your car stopped at time of impact: ☐Yes ☐No
    If yes, was driver's foot on brake pedal: ☐Yes ☐No
    If yes, did you car move forward on impact: ☐Yes ☐No
    If no, were you: ☐Gaining speed ☐Slowing down ☐Traveling at steady speed
13. What was your approximate speed:__________ mph
14. Were there more than 2 cars involved in the accident: ☐Yes, How many? _____
    ☐No ☐Another object involved__________
15. How fast was the other vehicle traveling: __________mph
16. Was the other vehicle: ☐Gaining speed ☐Slowing down ☐Traveling a steady speed
17. What type of car impacted you:__________

18. In your own words, please describe the accident. Include what you heard, saw, or felt: __________

19. Please describe how you felt. Did you feel pain:
   A) DURING the accident: ______
   B) IMMEDIATELY FOLLOWING the accident: ______
   C) THE FOLLOWING DAY: ______
20. Estimated cost of damage to your vehicle: ______ Totaled? ☐Yes ☐No Photo of Damage? ☐Yes ☐No
21. CIRCLE which of the following car parts were damaged during the accident:
   A) Windshield
   B) Right side of vehicle
   C) Left side of vehicle
   D) Front of vehicle
   E) Rear of vehicle
   F) Other______
22. Did you receive emergency care IMMEDIATELY following the accident: ☐Yes ☐No If yes, type of treatment, where, and name of doctor:______
   If yes, how did you get there? ☐Ambulance ☐Private Transportation
   If yes, were x-rays taken? ☐Yes ☐No
   Was other imaging performed (e.g. CT scan, MRI, diagnostic ultrasound)? ☐Yes ☐No
23. Have you been treated by another doctor since the accident: ☐Yes ☐No
   If yes, doctor's name and treatment received: ______
   ______
   Was medication prescribed? ☐Yes ☐No
   If yes, what medications:______
   ______
24. Since the injury occurred, are symptoms: ☐Improving ☐Getting Worse ☐Same ☐Comes and goes
25. Have you been able to work since the injury? ☐Yes ☐No
26. Type of work you are employed in: ______
27. Since the accident do you notice any activity restrictions in your capacity for:
Work: ______
______
Family: ______
______
Recreation: ______
______
Chores: ______
______

28. Have you ever been involved in an accident before: ☐Yes ☐No If yes, describe (include dates, type of accident, and injury(s) received):______
______
______
______

29. Is there a possibility you may be pregnant? ☐Yes ☐No

Height: ______ Weight: ______ ☐ Left-Handed ☐ Right-Handed

SYMPTOMS

CHECK THE APPROPRIATE BOX:

Symptoms	Before Accident	After Accident	Symptoms	Before Accident	After Accident
Neck Pain			Headaches		
Neck Stiffness			"Pressure in head"		
Upper Back Pain			Head seems Heavy		
Mid Back Pain			Loss of Memory		
Low Back Pain			Dizziness		
Shoulder Pain			Fainting		
Elbow Pain			Balance Problems		
Wrist Pain			Blurred Vision		
Arm Pain			Nausea or Vomiting		
Leg Pain			Ears Ringing		
Hip Pain			Sensitivity to Light		
Knee Pain			Sensitivity to Noise		
Foot Pain			Feeling Slowed Down		
Chest Pain			Feeling like "In a Fog"		
Jaw Pain			"Don't Feel Right"		
Numb Head/Face			Difficulty Concentrating		
Tingling Head/Face			Difficulty Remembering		
Numb Arm/Hand			Fatigue or low energy		
Tingling Arm/Hand			Confusion		
Numb Leg/Foot			Drowsiness		
Tingling Leg/Foot			Sleeping Problems		
Diarrhea			More Emotional		
Constipation			Irritability		
Face Flushing			Depression/Sadness		
Fever			Nervous/Anxious		
Cold Sweats			Loss of Taste		
Feet Cold			Loss of Smell		
Hands Cold			Shortness in Breath		
Pain with Breathing					

SYMPTOMS other than above: ______________________________

____

____

____

Other pertinent information:

____

____

____

____

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INFORMED CONSENT TO CHIROPRACTIC CARE

TERMS OF ACCEPTANCE FOR CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health.

Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxation is a disturbance to the nervous system that occurs when one or more of the 24 vertebrae in the spinal column becomes misaligned and/ or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/ or reduced by an adjustment.

Adjustment is the specific application of forces to correct and/ or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as extremity adjustment, physiotherapy and/ or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

______________________________ ______________________________

Print Name **Signature**

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, ____________________ being the parent or legal guardian of ____________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/ her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ______________

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): ______________________________ DATE: __________

AGE: __________ DATE OF BIRTH: __________ OCCUPATION: __________

HOW LONG HAVE YOU HAD NECK PAIN? ____ YEARS ____ MONTHS ____ WEEKS

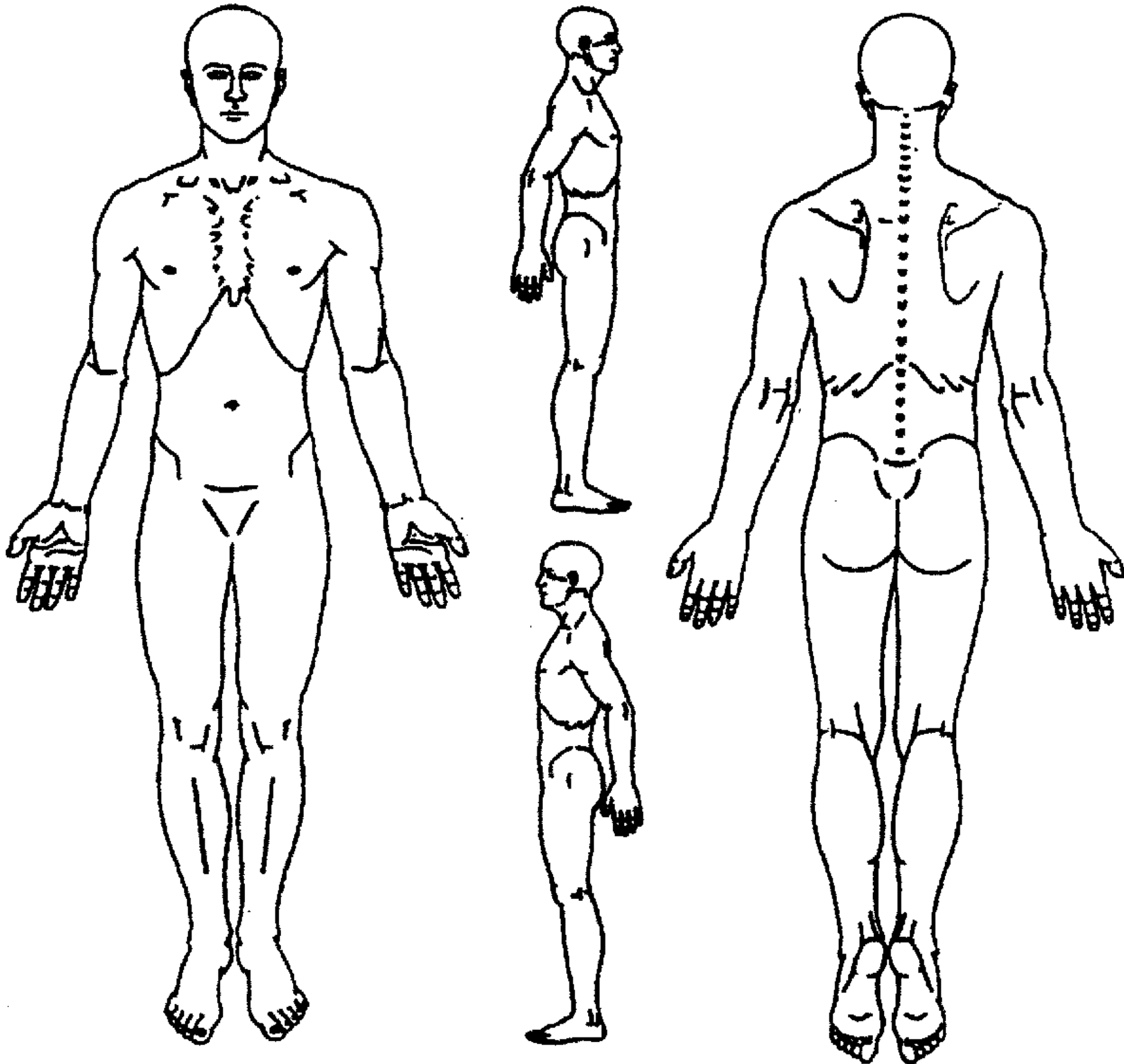
IS THIS YOUR FIRST EPISODE OF NECK PAIN? ____ YES ____ NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form)

KEY:

A = ACHE	B = BURNING	N = NUMBNESS
P = PINS & NEEDLES	S = STABBING	O = OTHER



OVER PLEASE

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE, WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 – Pain Intensity

A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care

A. I can look after myself normally without causing extra pain.
B. I can look after myself normally, but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 – Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want to with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5 – Headaches

A. I have no headaches at all.
B. I have slight headaches, which come infrequently.
C. I have moderate headaches, which come infrequently.
D. I have moderate headaches, which come frequently.
E. I have severe headaches, which come frequently.
F. I have headaches almost all the time.

After Vernon & Mior, 1991
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SECTION 6 – Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7 – Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8 – Driving

A. I can drive my car without any neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9 – Sleeping

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10 – Recreation

A. I am able to engage in all of my recreational activities, with no neck pain at all.
B. I am able to engage in all of my recreational activities, with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.

REVISED 1/1/95

Comments: ______________________________

Patient's Signature: ______________________________ **Date:** ____________

ROLAND-MORRIS ACUTE LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): ______________________________ DATE: ____________

AGE: ________ DATE OF BIRTH: ________ OCCUPATION: ______________

HOW LONG HAVE YOU HAD LOW BACK PAIN? ____ YEARS ____ MONTHS ____ WEEKS

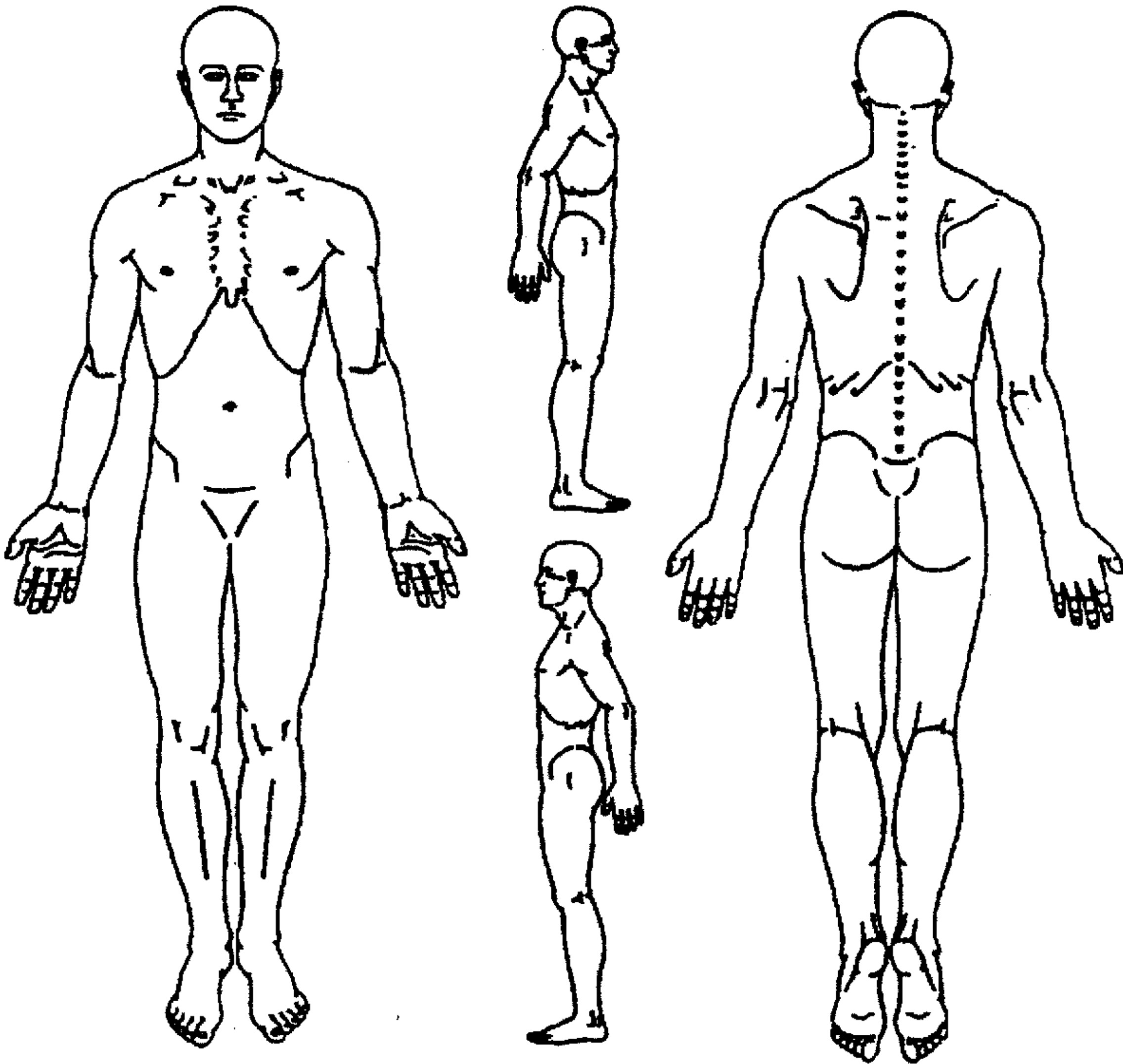
IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? ____ YES ____ NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form)

KEY:

A = ACHE	B = BURNING	N = NUMBNESS
P = PINS & NEEDLES	S = STABBING	O = OTHER



OVER PLEASE

ROLAND-MORRIS ACUTE LOW BACK PAIN DISABILITY QUESTIONNAIRE

When your back hurts, you may find it difficult to do some of the things you normally do.

This list contains some sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you *today*. As you read the list, think of yourself *today*. Check the box next to any sentence that describes you *today*. If the sentence does not describe you, then leave the space blank and go on to the next one. Remember, only check the sentence if you are sure that it describes you *today*.

1. ☐ I stay at home most of the time because of my back.
2. ☐ I change position frequently to try and get my back comfortable.
3. ☐ I walk more slowly than usual because of my back.
4. ☐ Because of my back, I am not doing any of the jobs that I usually do around the house.
5. ☐ Because of my back, I use a handrail to get upstairs.
6. ☐ Because of my back, I lie down to rest more often.
7. ☐ Because of my back, I have to hold on to something to get out of an easy chair.
8. ☐ Because of my back, I try to get other people to do things for me.
9. ☐ I get dressed more slowly than usual because of my back.
10. ☐ I only stand up for short periods of time because of my back.
11. ☐ Because of my back, I try not to bend or kneel down.
12. ☐ I find it difficult to get out of a chair because of my back.
13. ☐ My back is painful almost all the time.
14. ☐ I find it difficult to turn over in bed because of my back.
15. ☐ My appetite is not very good because of my back pain.
16. ☐ I have trouble putting on my socks (or stockings) because of the pain in my back.
17. ☐ I only walk short distances because of my back pain.
18. ☐ I sleep less well because of my back pain.
19. ☐ Because of my back pain, I get dressed with help from someone else.
20. ☐ I sit down for most of the day because of my back.
21. ☐ I avoid heavy jobs around the house because of my back.
22. ☐ Because of my back pain, I am more irritable and bad tempered with people than usual.
23. ☐ Because of my back pain, I go upstairs more slowly than usual.
24. ☐ I stay in bed most of the time because of my back.

SIGNATURE: ______________________________ DATE: ______________

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Appendix 1: Disability Questionnaire from "A Study of the Natural History of a Reliable and Sensitive Measure of Disability in Low Back Pain." Spine 1983; 8(2): 141-4.

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