

**Carol Harris Lipschultz, D.C., D.N.B.H.E.**

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\_\_\_\_\_  
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651-644-9691  
651-644-3815 (fax)

**PERSONAL INJURY - PATIENT DATA FORM**

Name \_\_\_\_\_ Date \_\_\_\_\_

10 Date of Accident \_\_\_\_\_ Time \_\_\_\_\_ (AM/PM)  
Driver of car \_\_\_\_\_ Where were you seated? \_\_\_\_\_  
Who owns the car? \_\_\_\_\_ Year and model of car \_\_\_\_\_  
What was the approximate damage done to your car? \$ \_\_\_\_\_

20 Visibility at time of accident: poor fair good other: \_\_\_\_\_  
Road conditions at time of accident: icy rainy and wet clear dark other: \_\_\_\_\_  
Where was your car struck? right left rear front side other: \_\_\_\_\_  
Type of accident:  head-on collision  
 rear-end collision  
 broad-side collision  
 front impact, rear-ended car in front  
 non-collision: \_\_\_\_\_

30 Describe in your own words what happened to you upon impact \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you see the accident coming? yes no  
Did you brace for impact? yes no  
Were seat belts worn? yes no  
Were shoulder harnesses worn? yes no  
40 Does your car have headrests? yes no

50 If yes, what was the position of those headrests compared to your head before the accident?  
 top of headrest even with bottom of head  
 top of headrest even with top of head  
 top of headrest even with middle of neck

60 Was your car braking? yes no

70 Was your car moving at the time of accident? yes no

80 If yes, how fast would you estimate you were going? \_\_\_\_\_ m.p.h.

90 How fast was the other car traveling? \_\_\_\_\_ m.p.h.

100 Head/body position at time of impact:  head turned left/right  
 head looking back  
 head straight forward

**PERSONAL INJURY - PATIENT DATA FORM**

Name \_\_\_\_\_ Date \_\_\_\_\_

body straight in sitting position

body rotated left/right

other: \_\_\_\_\_

110 At the time of accident, recall what parts of your head or body hit what parts on the inside of your car \_\_\_\_\_ S

120 As a result of the accident you were:

rendered unconscious

dazed, circumstances vague

other: \_\_\_\_\_

130 Could you move all parts of you body?                      yes    no

140 If no, what parts and why? \_\_\_\_\_

150 Were you able to get out of the car and walk unaided?                      yes    no

160 If no, why not? \_\_\_\_\_

10 Did you get bleeding cuts or bruises?                      yes    no

20 If yes, what bleeding cuts did you get from this accident? \_\_\_\_\_

If yes, what bruises did you get from this accident? \_\_\_\_\_

30 Please describe how you felt immediately after the accident. Please be specific. \_\_\_\_\_

40 Later that day \_\_\_\_\_

Later that night \_\_\_\_\_

50 The next day \_\_\_\_\_

The next couple of days \_\_\_\_\_

60 Check symptoms apparent since the accident:

headache

neck pain/stiffness

mid back pain

low back pain

eyes sensitive to light

pain behind eyes

dizziness

fainting

ringing/buzzing ears

loss of balance

loss of smell

loss of taste

loss of memory

fatigue

tension

shortness of breath

irritability

depression

sleeping problems

numbness in toes

numbness in fingers

cold hands

cold feet

diarrhea

constipation

chest pain

nervousness

cold sweats

anxious

other

**PERSONAL INJURY - PATIENT DATA FORM**

Name \_\_\_\_\_ Date \_\_\_\_\_

10 Occupation \_\_\_\_\_ Employer \_\_\_\_\_

20 Have you missed time from work?            yes    no

30 If yes,

40 Full time off work: \_\_\_\_\_ to \_\_\_\_\_: \_\_\_\_\_ to \_\_\_\_\_

50 Part-time off work: \_\_\_\_\_ to \_\_\_\_\_: \_\_\_\_\_ to \_\_\_\_\_

60 Have you been unable to work since the time of the accident to the present?    yes    no

10 Did you go to seek medical help immediately/soon after the accident?            yes    no

20 If yes, how did you get there?

someone else drove me

drove own car

ambulance

police

other \_\_\_\_\_

Doctor 1/Hospital/Clinic seen \_\_\_\_\_ Date \_\_\_\_\_

Were you examined?    yes    no            Were X-rays taken?    yes    no

30 Were you given treatment?            yes    no

40 If yes, what treatment was given to you?

bed rest

brace

physiotherapy

adjustments

drugs

other \_\_\_\_\_

What benefits did you receive from the treatment? \_\_\_\_\_

Date of last treatment \_\_\_\_\_

10 Doctor 2/Hospital/Clinic seen \_\_\_\_\_ Date \_\_\_\_\_

20 Were you examined?    yes    no            Were X-rays taken?    yes    no

30 Were you given treatment?            yes    no

40 If yes, what treatment was given to you?

bed rest

brace

physiotherapy

adjustments

drugs

other \_\_\_\_\_

What benefits did you receive from the treatment? \_\_\_\_\_

Date of last treatment \_\_\_\_\_

10 Doctor 3/Hospital/Clinic seen \_\_\_\_\_ Date \_\_\_\_\_



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**CAR ACCIDENT PATIENT**

In your own words describe the accident.

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**ACTIVITY RANGE MONITOR**

Name \_\_\_\_\_ Date \_\_\_\_\_

**Idea List for Usual Activities**

For use in filling out the Activity Range Monitor.

Use this list to help you remember activities that you normally do with or without pain or difficulty.

**Daily Activities**

Activities relating to driving

Caring for children: list main problematic areas

**Mental and Mood Effects** *(These are things that represent a change from your usual state of functioning. Here are some possibilities.)*

Hard to think clearly

Poor concentration

Hard to hold a mental focus (at times, frequently, always)

Lowered stress tolerance

Irritability

Anxiety

Depression

**Work** *(Think about your usual work tasks. Has anything affected your ability to do these? List the specific task that is important to your work that is now a problem. These are some ideas.)*

Sitting in meetings

Typing or computer work

Phone work

Doing work with arms out in front of body (you can list the specific task)

Carrying things (trays, tools, books/files, etc.)

Bending over for tasks (list if there is something specific)

Lifting, carrying, reaching or other movements

**Recreational Activities** *(List the more frequently performed activities first and then list the activities that are performed occasionally. Include any that are not on the list.)*

Aerobics

Backpacking

Bicycling

Canoeing

Camping

Dancing

Gardening

Golf

Lifting Weights

Rollerblading

Skiing - Downhill/Cross Country

Softball

Swimming

Walking: \_\_\_\_\_ miles or \_\_\_\_\_ minutes

Water skiing

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SUBJECTIVE COMPLAINTS

Name \_\_\_\_\_ Date \_\_\_\_\_

Please Print
10. Explain WHEN and HOW it happened: \_\_\_\_\_

20. COMPLAINTS / SYMPTOMS: [ ] Come and go [ ] Came on gradually [ ] Came on suddenly

30. Symptoms persisted for: [ ] Hours [ ] 1 Day [ ] Days [ ] Weeks [ ] Months [ ] Years

40. Symptoms developed from: [ ] A work-related injury [ ] An auto accident [ ] An injury other than at work or an auto accident

50. DESCRIBE COMPLAINTS: PLEASE BE SPECIFIC

Involving Neck & Head: \_\_\_\_\_

Involving Mid-back/ Shoulders/ Arms & Hands: \_\_\_\_\_

Involving Low Back/ Hips/ Legs & Feet: \_\_\_\_\_

60. What activities make condition WORSE? \_\_\_\_\_

70. What activities make condition BETTER? \_\_\_\_\_

80. Have you ever had this condition / problem before: [ ] Yes [ ] No

90. If yes, when? \_\_\_\_\_

100. Give names(s) and address(es) of doctor(s) previously seen for the present complaint. \_\_\_\_\_

110. What medications are you presently taking? \_\_\_\_\_ For what condition? \_\_\_\_\_

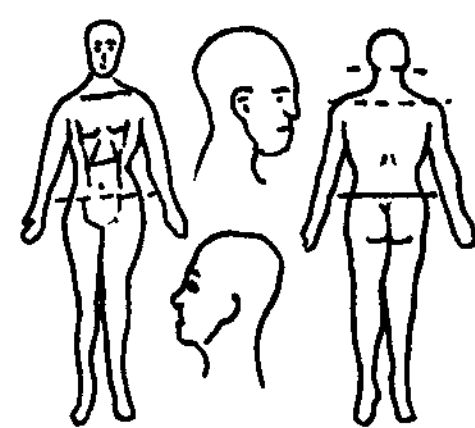
20-50. INDICATE ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:

230. SHADE AND CODE AREA(S) TO INDICATE LOCATION OF PAIN OR DISCOMFORT:

USE CODES:
U - Unable P- Painful D- Difficult L-Limited N-Normal

USE CODES:
P- Pain N- Numbness S- Spasm T- Tenderness

- Coughing or sneezing
Getting in or out of a car
Bending forward to brush teeth
Turning over in bed
Walking short distance
Standing for more than 1 hour
Sitting at a table
Lying on Back
Lying flat on stomach
Lying on side with knees bent
Bending over forward
Climbing
Kneeling
Balancing
Dressing Self
Sleeping
Stooping
Gripping
Pushing
Pulling
Reaching
Sexual activity



- 60. CHECK SYMPTOMS OF NERVOUS STRESS
[ ] Blurry vision
[ ] Buzzing or ringing in ears
[ ] Confusion
[ ] Convulsions
[ ] Headaches
[ ] How often do you have headaches? \_\_\_\_\_
[ ] Loss of sleep

# SUBJECTIVE COMPLAINTS

Name \_\_\_\_\_ Date \_\_\_\_\_

- Depression or Crying spells
- Dizziness
- Fainting
- Paralysis
- Low resistance
- Muscle jerking
- Numbness

240. (WOMEN ONLY) Are you pregnant?  Yes  No

Date of onset of last menstrual cycle \_\_\_\_\_

250. Give date of last x-rays: \_\_\_\_\_

70. Symptoms are BETTER in:  AM  Midday  PM

What body parts were they taken of? \_\_\_\_\_

80. Symptoms are WORSE in:  AM  Midday  PM

\_\_\_\_\_

90.  Symptoms do not change at with time of day

Name \_\_\_\_\_ File # \_\_\_\_\_

100. FAMILY HISTORY: (for example: Cancer, Diabetes, Heart Problems, / Back or Neck Problems)

Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Occupation \_\_\_\_\_

Father:

Mother:

Brother/ Brothers:

Sister/ Sisters:

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Bicycling

Canoeing

Camping

Dancing

Gardening

Golf

Lifting Weights

Rollerblading

Skiing - Downhill/Cross Country

Softball

Swimming

Walking: \_\_\_\_\_ miles or \_\_\_\_\_ minutes

Water skiing

## ACTIVITY RANGE MONITOR

Name \_\_\_\_\_

Date \_\_\_\_\_

Indicate your ability to perform the following activities. Circle what best applies. "OK" means that the activity is the same for you as before the injury.

Add any comments you like after the activity. Use the blank lines to fill in activities that are bothering you and not on the list.

radiating pain		local pain		OK	Coughing or Sneezing
unable	pain	difficult	limited	OK	Getting in or out of car
unable	pain	difficult	limited	OK	Riding in a car for short distances
unable	pain	difficult	limited	OK	Driving several hours
unable	pain	difficult	limited	OK	Bending forward to brush teeth
unable	pain	difficult	limited	OK	Washing/drying hair
unable	pain	difficult	limited	OK	Turning over in bed
unable	pain	difficult	limited	OK	Sleep
unable	pain	difficult	limited	OK	Standing for 10 minutes
unable	pain	difficult	limited	OK	Standing for 1 hour or more
unable	pain	difficult	limited	OK	Sitting for 10 minutes
unable	pain	difficult	limited	OK	Sitting for 1 hour or more
unable	pain	difficult	limited	OK	Lying on your back
unable	pain	difficult	limited	OK	Lying on your side with knees bent
unable	pain	difficult	limited	OK	Bending forward
unable	pain	difficult	limited	OK	Climbing stairs (Pain with how many steps ___ or flights ___)
unable	pain	difficult	limited	OK	Kneeling
unable	pain	difficult	limited	OK	Dressing Self
unable	pain	difficult	limited	OK	Stooping
unable	pain	difficult	limited	OK	Gripping objects
unable	pain	difficult	limited	OK	Carrying objects
unable	pain	difficult	limited	OK	Turning door knobs
unable	pain	difficult	limited	OK	Pushing
unable	pain	difficult	limited	OK	Pulling
unable	pain	difficult	limited	OK	Reaching for objects in front of you
unable	pain	difficult	limited	OK	Reaching overhead
unable	pain	difficult	limited	OK	Handwriting
unable	pain	difficult	limited	OK	Sexual activity
					<b>House Work/Home Maintenance</b>
unable	pain	difficult	limited	OK	Washing dishes
unable	pain	difficult	limited	OK	Changing sheets
unable	pain	difficult	limited	OK	Vacuuming
unable	pain	difficult	limited	OK	Sweeping
unable	pain	difficult	limited	OK	Washing floor
unable	pain	difficult	limited	OK	Washing windows
unable	pain	difficult	limited	OK	Scrubbing tub
unable	pain	difficult	limited	OK	Grocery shopping
unable	pain	difficult	limited	OK	Carrying groceries
unable	pain	difficult	limited	OK	Painting
unable	pain	difficult	limited	OK	Snow shoveling

# ACTIVITY RANGE MONITOR

Name \_\_\_\_\_ Date \_\_\_\_\_

unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK

Gutter cleaning  
 Pet care  
 Mowing  
 Raking  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Work Related**

unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK

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**Recreational (Usual Activities)**

List frequent activities first, then occasional

unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK
unable	pain	difficult	limited	OK

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## Symptom Log

Name \_\_\_\_\_

### Patient Notes

DATE \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATE \_\_\_\_\_

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**PATIENT INSURANCE RECORD- CAR ACCIDENT**

**PATIENT INFORMATION**

Patient's Legal Name \_\_\_\_\_  
(last) (first) (middle initial)

Patient Social Security No. \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: Male  Female

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_  
(city) (state) (ZIP code)

Patient's Employer \_\_\_\_\_ Employer's Phone \_\_\_\_\_

Employer's Address \_\_\_\_\_  
(city) (state) (ZIP code)

Marital Status: Married  Single  Widowed

**INSURED INFORMATION**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
(last) (first) (middle initial)

Insured's Social Security No. \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: Male  Female

Insured's Home Phone \_\_\_\_\_ Insured's Work Phone \_\_\_\_\_

Insured's Address \_\_\_\_\_  
(city) (state) (ZIP code)

Insured's Employer \_\_\_\_\_ Employer's Phone \_\_\_\_\_

Employer's Address \_\_\_\_\_  
(city) (state) (ZIP code)

**INSURANCE INFORMATION**

Insurance Co's Name \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Co.'s Address \_\_\_\_\_  
(city) (state) (ZIP code)

Attention \_\_\_\_\_ Claim No. \_\_\_\_\_ Date of Incident \_\_\_\_\_

Was the auto accident in MN? yes  no  Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

**LAWYER INFORMATION**

Lawyer's Name \_\_\_\_\_ Phone \_\_\_\_\_

Lawyer's Address \_\_\_\_\_  
(city) (state) (ZIP code)

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**FINANCIAL AGREEMENT**

I am the responsible party for payment of all expenses and services incurred with this office.

I understand that this office will bill my auto insurance for services with the doctor. I am responsible for paying any balance for which the insurance does not pay.

I will pay for nutritional supplements at the time I receive them. I understand these are not billed to my insurance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Printed)

\_\_\_\_\_  
Social Security Number

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**Payment Release Form**

Please release payment directly to the billing physician.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Printed)

\_\_\_\_\_  
Social Security Number