PATIENT INFORMATION

For Office use Only
Patient #

Patient's First Name_____ Middle_____ Last_____ Date _____

Address _____ City _____ Zip Code _____

Home Phone _____ Cell Phone_____

E-mail _____ Social Security # _____

Employer Name _____

Job Title _____ Work Phone # _____

Date of Birth _____ Age____ Gender ☐ Male ☐ Female Handedness? R L

Weight_____ Height _____ Marital Status S M W D

Spouse's Name_____ Spouse's Date of Birth _____

Person responsible for this account_____

Health Insurance Company _____ Phone number_____

Policy/Member ID #_____ Group #_____

Address _____ City _____ Zip Code _____

Adjuster _____ Phone Number _____

Name of the insurance card holder_____

Social Security # of card holder _____

Name of their employer_____ Employer Phone #_____

Children names and ages_____

Car Insurance Company _____

Address _____ City _____ Zip Code _____

Adjuster _____ Phone #_____

Agent _____ Phone # _____

Policy # _____ Claim # _____

Drivers License # _____

Name of Insured on your Car Policy _____ Date of Loss/Accident? _____

Medical Coverage? _____ Uninsured Motorist Coverage? _____

Underinsured Motorist Coverage?_____

Personal Injury Protection (PIP) Y N $_____

Medical expenses to date as a result of the accident? $_____

Lost wages since accident $_____

What is the repair amount of your car? $ _____

Lawyer/ Law Firm_____ Phone #_____

Address _____City _____Zip Code _____

In case of emergency, whom should we contact? _____

Phone #_____

Family physician_____ Phone #_____

Address_____ City_____ Zip Code_____

Date you first saw any Doctor after accident _____

Is this Workman's Compensation? _____Is this Personal Injury?_____

Have you received any medical treatment since your accident? Y N

Hospital_____Cost_____

Medical Doctor _____Cost_____

Chiropractor_____Cost_____

Other_____Cost_____

SYMPTOMS

Patient's Name_____ Date of incident _____Today's Date_____

CIRCLE ALL YOU COMPLIANTS

1. DO YOU HAVE LACERATIONS, CUTS OR BRUISING? :
   a. Head or Face
   b. Neck
   c. Seat belt bruising
   d. Cuts or bruising on your chest
   e. Cuts or bruising on arms
   f. Cuts or bruising on legs
   g. Other: _____
2. HEAD INJURIES: (now or at the time of the accident)
   a. Were you knocked out or unconscious
   b. Headaches
   c. Face pain
   d. Pupils different sizes
   e. Dizziness
   f. Difficulty walking
   g. Balance problems
   h. Room spins
   i. Disoriented Confusion
   j. Day dreaming
   k. Attention problems
   l. Hearing problems
   m. Change in sense of smell or taste
   n. Difficulty speaking
   o. Memory problems
   p. Very tired or fatigued
   q. Appetite change
   r. Sleep difficulties
   s. Visual Disturbances, blurry or double vision
   t. Flashbacks to accident
   u. Problems to read or write
   v. Problems adding or subtracting
   w. Problems learning new things
   x. Problems understanding
   y. Problems remembering numbers
   z. Difficulty Concentrating
   aa. Difficulty remembering things
   bb. Difficulty making decisions
   cc. Change in Sexual Functioning
   dd. Nausea / Vomiting
   ee. Change of personality
   ff. Wanting to be alone
   gg. Mood swings
   hh. Sadness
   ii. Agitation
   jj. Anger
   kk. Helplessness
   ll. Reduce confidence
   mm. Apathy
   nn. Irritability
   oo. Sleepiness
   pp. Frustration
   qq. Impatience
   rr. Other head related issues

   _____
3. JAW PROBLEMS:
   a. Jaw pain
   b. Clicking
   c. Pain while chewing
   d. Pain while talking
   e. Pain while yawning
   f. Pain while moving jaw from side to side
4. NECK INJURIES:
   a. Neck pain
   b. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
   c. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
   d. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT UPPER BACK
   e. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT UPPER BACK
   f. Neck pain that causes headaches
   g. Neck spasms or shoulder spasms
   h. Popping, clicking or clunking sound with neck movement

5. SHOULDER INJURIES
   a. Shoulder pain LEFT RIGHT BOTH
   b. Shoulder pain with movement L R BOTH
   c. Shoulder spasms LEFT RIGHT BOTH
   d. Sharp shoulder pain
   e. Dull shoulder pain
   f. Achy shoulder pain
   g. Pins and needles shoulder pain
   h. Shoulder pain that radiates or shoots pain into arm
   i. Other:

_____

6. UPPER ARM PAIN: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

7. ELBOW PAIN: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

8. FOREARM: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

9. WRIST PAIN: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

10. HAND PAIN: RIGHT LEFT BOTH
    a. Dull
    b. Ache
    c. Sharp
    d. Stabbing
    e. Other

_____

11. MID BACK PAIN OR UPPER BACK PAIN
    a. Upper or mid back pain
    b. Upper back pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
    c. Upper back pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
    d. Upper or mid back spasms

12. LOW BACK PAIN:
    a. Low back pain
    b. Low back pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
    c. Low back pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
    d. Low back spasms

13. PELVIC OR SACRAL PAIN
    a. Pelvic pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
    b. Pelvic pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
    c. Sacral pain (tail bone)
    d. Coccygeal or coccyx (tail bone) pain

14. HIP PAIN: RIGHT LEFT BOTH
    a. Hip pain
    b. Hip pain, numbness, tingling, weakness that radiates or goes down to buttock, thigh, leg or foot

15. UPPER LEG PAIN: RIGHT LEFT BOTH
    a. Upper leg pain that radiates to knee
    b. Upper leg spasms

16. KNEE PAIN: RIGHT LEFT BOTH
    a. Knee pain that radiates to calf
    b. Knee pain that radiates to calf and ankle
    c. Knee pain that radiates to calf, ankle and foot
17. ANKLE PAIN: RIGHT LEFT BOTH
    a. Ankle pain that radiates to foot
    b. Ankle and foot pain
18. FOOT PAIN: RIGHT LEFT BOTH
19. CHEST PAIN
20. STOMACH PAIN
21. OTHER SYMPTOMS:

_____
_____
_____
_____

CAD Injury History Form

General information:

Patient' name: _____
Today's date: _____
Date of injury: _____
Marital status: ☐ M ☐ S ☐ W ☐ D
Habits:
Smoke: ☐ None Pk/day ____ Years ____
Alcohol: ☐ Never ☐ Social ☐ Light ☐ Mod. ☐ Heavy
Employment:
At time of crash: _____
☐ Unemployed
Currently: _____
☐ Unemplyed
Due to crash? ☐ Yes ☐ No
Type of work: ☐ Office/clerical ☐ Light labor ☐ Moderate labor ☐ Heavy labor

Past medical history:

Surgeries (dates and residuals): _____

Fractures (dates and residuals): _____

Serious illness (dates and residuals): _____

Workers' comp. injuries (date, TX, awards, residuals): _____

Personal Injuries (date, TX, awards, residuals):

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

Past medical history (cont'd)

Any prior HX of current complaints:
1. _____
2. _____
3. _____
Prior TX by DC for these:
1. _____
2. _____
3. _____

Current Medical history:

Current health problems: ☐ None

Current medications taken: ☐ None

Injury history. General:

Was the crash on-the-job? ☐ Yes ☐ No
You were: ☐ Driver ☐ Front seat passenger ☐ Rear seat passenger ☐ Motorcycle operator ☐ Motorcycle passenger ☐ Other _____
Vehicle driven by: _____
Your vehicle (year, make, model): _____
Your estimated speed at moment of crash: _____
☐ Stopped ☐ Slowing ☐ Accelerating
Other vehicle (year, make, model): _____
Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark
Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other _____
Head restraints: ☐ None ☐ Integral type ☐ Adjustable type: ☐ Up ☐ Down ☐ Don't know
If adjustable, was the position altered by the crash? ☐ Yes ☐ No
Was the seat back adjustment altered by the crash? ☐ Yes ☐ No
Was the seat broken? ☐ Yes ☐ No
Lap belt: ☐ Wearing ☐ Not wearing ☐ Don't know
Shoulder belt: ☐ None ☐ Wearing ☐ Not wearing ☐ Don't know
Did air bag deploy? ☐ Yes ☐ No
If yes, were you struck? ☐ Yes ☐ No
Body position: ☐ Good ☐ Forward lean Other _____
Head position: ☐ Forward ☐ Left ___° ☐ Right ___° ☐ Up ___° ☐ Down ___°

Injury history. General: (cont'd)

Hands: ☐ One on wheel ☐ Two on wheel ☐ N/A
Brakes applied? ☐ Yes ☐ No
Crash description: _____

Crash diagram:

Aware of impending crash? ☐ Yes ☐ No

During the crash:

Did you strike any parts of the vehicle? ☐ Y ☐ N
If yes, describe _____
Did vehicle strike any objects after crash?
If yes, describe _____
Wearing hat or glasses? ☐ Yes ☐ No
If yes, still on after crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
If yes, for how long? _____
Estimated property damage to your vehicle:
$ _____
Estimated damage to other vehicle(s): ☐ None ☐ Minimal ☐ Moderate ☐ Major
Were the police on-scene? ☐Yes ☐No
If yes, was a report made? ☐Yes ☐No

After the crash:

Symptoms: ☐ Headache ☐ Dizziness ☐ Nausea ☐ Confusion/disorientation ☐ Neck pain ☐ Paresthesia(s)
If yes, where? _____
☐ Extremity pain. If yes, where? _____
☐ Back pain
When did SX first appear? ☐ Immediately
(describe which SX) _____ hr afterward
Where did you go after crash? ☐ Home ☐ Work ☐ Hospital:
Mode of transportation _____
Pvt. doctor: _____

Emergency department:

Radiographs: ☐ Yes ☐ No
Body parts imaged _____
Results _____
Lab work ☐ Yes ☐ No _____
☐ Cervical collar ☐ Ice
Medications: _____
Other: _____
Follow-up instructions: ☐ None _____

Treatment history:

1. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? ☐ Yes ☐ No
Notes: _____

2. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? ☐ Yes ☐ No
Notes: _____

Current chief complaints:

1. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

2. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

3. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

4. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

5. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

Self assessment as of today: % improved (list for separate areas)

_____
_____
_____

Request records:

☐ 1. Request radiographs from: _____
_____

☐ 2. Request records from: _____
_____

☐ 3. Request copy of police report.

Referral:

☐ For: _____
☐ To: _____

Tests to order:

☐ Radiographs: _____
☐ Tomograms: _____
☐ CT: _____
Area(s): _____
☐ MRI: _____
Area(s): _____
☐ MRA: _____
Area(s): _____
☐ Scintigraphy/SPECT: _____
Area(s): _____
☐ Videofluoroscopy: _____
Area(s): _____
☐ EMG/NCV: _____
Root level/nerve(s): _____
☐ SEP: _____
Root level/nerve(s): _____
☐ Other electrodiagnostic test(s): _____
☐ Ultrasound: _____
Area(s): _____

Action taken on this visit:

☐ Exam/TX: _____
_____
☐ Place on disability: _____
☐ Work restriction: _____
☐ Referral: _____
☐ Brace/collar: _____
☐ Home traction device: _____
☐ NEXERCICER: _____
☐ Supplements: _____
☐ Other: _____

Treatment history: (cont'd)

3. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? ☐ Yes ☐ No
Notes: _____

4. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? ☐ Yes ☐ No
Notes: _____

5. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? ☐ Yes ☐ No
Notes: _____

6. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? ☐ Yes ☐ No
Notes: _____

Original chief complaints (if injury was not recent):

1. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

2. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

3. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

4. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

5. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

Duties Performed Under Duress at Work and Home

Patient name_____ Date of Injury _____ Today's Date_____

☐ Initial ☐ Update

Please check all that apply to your WORK because of the accident

- ☐ I go to work but work in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the computer at work hurts
- ☐ Pushing at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ _____
- ☐ _____
- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't use to
- ☐ I hide my poor work performance from my boss
- ☐ _____
- ☐ _____

Please check all that apply to your HOME/DOMESTIC because of the accident

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ _____
- ☐ _____
- ☐ I cannot take time off because I care for children
- ☐ I have _____children ages_____
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yard work like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the work now
- ☐ Others living with me do my share of the yard now
- ☐ Others living with me do my share of the gardening
- ☐ _____

_____ _____

Signature Date

Loss of Enjoyment of Sports, Hobbies, Travel, Daily activities, & School (1 of 2 pages)

Patient's name _____ Date of Injury_____ Today's date_____

☐ Initial ☐ Update

Please check all that apply to your EXERCISE & SPORTS Activity because of the accident

☐ My exercise was affected by this crash	☐ I have gained_____ pounds since the accident
☐ I go to the gym & work out in pain	☐ I had to quit my _____ team after the accident
☐ I no longer go to the gym to work out	☐ I had to quit my _____ team after the accident
☐ I run but in pain	☐ I had to quit my _____ team after the accident
☐ I no longer run	☐ I had to quit my _____ team after the accident
☐ I take walks & have pain while walking	☐ I don't enjoy the sport of _____anymore
☐ I no longer take walks	☐ I didn't enjoy the sport of _____for ____weeks
☐ I used to make income at sports	☐ I don't enjoy the sport of _____anymore
☐ I have lost sports income since crash	☐ I didn't enjoy the sport of _____for ____weeks
☐ I am an amateur athlete	☐ I don't enjoy the sport of _____anymore
☐ I am a professional athlete	☐ I didn't enjoy the sport of _____for ____weeks
☐ _____	☐ I don't enjoy the sport of _____anymore
☐ _____	☐ I didn't enjoy the sport of _____for ____weeks

Please check all that apply to your HOBBY Activities because of the accident

☐ My hobbies were affected by accident	☐ Hobby #3_____
☐ Hobby #1_____	☐ I can't do hobby #3 anymore
☐ I can't do hobby #1 anymore	☐ I do hobby #3 but in pain
☐ I do hobby #1 but in pain	☐ I have lost money from not doing #3
☐ I have lost money from not doing #1	☐ I didn't do hobby #3 for _____ weeks
☐ I didn't do hobby #1 for _____ weeks	☐ Hobby #4_____
☐ Hobby #2_____	☐ I can't do hobby #4 anymore
☐ I can't do hobby #2 anymore	☐ I do hobby #4 but in pain
☐ I do hobby #2 but in pain	☐ I have lost money from not doing #4
☐ I have lost money from not doing #2	☐ I didn't do hobby #4 for _____ weeks
☐ I didn't do hobby #2 for _____ weeks	☐ _____

Please check all that apply to your TRAVEL Activities because of the accident

☐ Business travel was affected by crash	☐ Travel Plan #1
☐ Pleasure travel was affected by crash	☐ I did not go on travel plan #1
☐ I hurt driving in my own car	☐ I went, but did not enjoy #1 as much
☐ I am in too much pain to drive	☐ I went and the accident had no effect on #1
☐ I hurt when a passenger in a car	☐ Travel Plan #2
☐ I am in too much pain to sit in a car	☐ I did not go on travel plan #2
☐ I have anxiety when I'm in a car	☐ I went, but did not enjoy #2 as much
☐ I hurt when I'm on an airplane	☐ I went and the accident had no effect on #2
☐ I am in too much pain too much pain to travel by plane	☐ I missed time with my family/friends b/c can't travel

Loss of Enjoyment of Sports, Hobbies, Travel, Daily activities, & School (2 of 2 pages)

Patient's name_____ Date of Injury_____ Today's date_____

☐ Initial ☐ Update

Please check all the DAILY LIVING activities that cause you pain because of the accident

- ☐ Dressing
- ☐ Putting on pants
- ☐ Putting on shoes
- ☐ Tying my shoes
- ☐ Putting on shirt
- ☐ Drying my hair
- ☐ Combing my hair
- ☐ Washing my hair
- ☐ Taking a shower
- ☐ Taking a bath
- ☐ Leaning forward
- ☐ Laying in bed
- ☐ Sitting in my favorite chair
- ☐ Sleeping
- ☐ Going out with my friends
- ☐ Sitting at a restaurant
- ☐ Shopping
- ☐ Driving to/from work
- ☐ Sitting in Church
- ☐ Playing with my children
- ☐ Caring for my children
- ☐ Bending in a movie theatre
- ☐ Sitting in a movie theatre
- ☐ Exercise
- ☐ Eating
- ☐ Stooping
- ☐ Squatting down
- ☐ Kneeling
- ☐ Brushing my teeth
- ☐ Riding in a car
- ☐ Opening a jar
- ☐ Lifting a pan when cooking
- ☐ Closing the trunk on my car
- ☐ Opening the garage door
- ☐ Using my home computer
- ☐ Climbing stairs
- ☐ Sexual activity
- ☐ Turning my head to left or right
- ☐ Holding my head up all day
- ☐ Watching TV
- ☐ I have pain sitting & doing nothing
- ☐ Talking on the phone
- ☐ Reading
- ☐ Writing
- ☐ Opening doors
- ☐ Drying with a towel after a bath or shower
- ☐ Life has become a chore just to do normal things
- ☐ It is depressing to live like this
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Please check all that apply to your SCHOOL & EDUCATION Activities because of the accident

- ☐ School was affected by the accident
- ☐ I am a student at _____
- ☐ I am in the _____ year/grade
- ☐ I was ☐ full time ☐ part time
- ☐ I am now ☐ full time ☐ part time
- ☐ I had to take fewer classes b/c of crash
- ☐ I missed _____ days of school
- ☐ I had to drop out of school b/c of crash
- ☐ My grades are lower since the crash
- ☐ I have pain carrying my school books
- ☐ I hurt sitting in class more than _____ minutes
- ☐ My neck hurts when I look down to read
- ☐ I don't learn as quickly as before the crash
- ☐ I don't learn things as well as before the crash
- ☐ I have difficulty concentrating in class
- ☐ It takes much longer to study/do my homework
- ☐ _____
- ☐ _____

_____ _____

Signature of Patient Date