Keefer CHIROPRACTIC Trusted Care
521 Yopp Rd. Ste 107
Jacksonville, NC 28540
910-333-9723

Pt Name: _____

Acct #: _____

ACCIDENT INFORMATION PAGE

Date of the accident:_____Time of the accident :_____ AM or PM

Describe in your own words, what happened in the accident:_____

_____

Where did the accident take place? (road, intersection, etc.) _____
What direction were you traveling in at the time of accident?_____ What direction was the other car traveling?_____
What state did the accident happen in? _____ What city did the accident happen in? _____
How many cars were involved in the accident? _____ What was the estimated damage to the car you were in? $_____
Where did the impact take place on the car? Front ____ Rear ___ Driver's Side ___ Passenger's Side ___ Other_____
What was the size of the car you were in? sub compact____compact_____mid-size_____ full size_____
What was the size of the other car? sub compact____ compact_____ mid-size_____ full size_____
What type of car were you in?_____ What type of car was the other car?_____
What was the visibility at the time of the accident? Clear____ sunny_____ dawn_____ dusk_____ night/dark_____ other_____
What were the road conditions? Dry____ Wet_____ Damp____ Snow_____ Icy_____ Clear_____ Other_____
Where were you sitting in the car? _____ Did you know that the accident was coming? No_____ Yes_____
Where you wearing a seatbelt? Lap belt: Yes_____ No_____ Shoulder Strap: Yes_____ No_____
Where you ejected from the car? Yes_____ No_____
Did you have a headrest? Yes____ No_____ Where was it positioned on your head?_____
Did the airbags deploy? Yes_____ No_____ Did you lose consciousness? Yes_____ No _____
Did your body hit anything in the car? No____ Yes(explain)_____
What body parts were injured? _____
Are there any or were there any cuts, bruising or bleeding after the accident on your body? No_____ Yes (explain) _____

Medical Treatment

Hospital/ER Treatment

Did you go to the hospital? No_____ Yes (where) _____ Date Treated at Hospital_____
Were you taken by ambulance? Yes_____ No (How did you get there?)_____
What Treatment was rendered at the hospital (medication, braces, etc.)? _____
Was there any imaging done (CT, MRI, X-rays, Etc.) ? No_____ Yes (explain) _____
Did this treatment help? No_____ Yes (explain) _____

Other Treatments

Have you seen any other doctor in relation to this accident outside of the ER? No____ Yes (Who?) _____
When was this medical treatment received? _____
Were any imaging studies taken (x-rays, CT scans, MRI, etc.)? No_____ Yes (what and of what area?) _____
What type of treatment did you receive (medication, collars, braces, etc.)? _____
Did the treatment received help your conditions? No_____ Yes _____

By signing below, I verify that all of the information provided above is true to the best of my knowledge. I, understand that by signing below I take full responsibility for the information provided in relation to the auto accident in which I was involved in. I also understand that ultimately I am responsible for any charges for the treatments rendered in relation to this accident.

Patient Name:_____ Patient Signature: _____ Date:_____

Witness: _____ Witness Signature: _____ Date: _____

Doctor's Signature:_____ Date: _____

Keefer CHIROPRACTIC Trusted Care

521 Yopp Rd. Ste 107
Jacksonville, NC 28540
910-333-9723

Pt. name: _____

Acct #: _____

Billing Information for Personal Injury Cases

Do you have an Attorney? No _____ Yes (who) _____

Contact Name: _____ Phone: _____

Liability Insurance (usually belongs to the person at fault in the accident)

Insurance Company Name: _____ Adjuster Name: _____

Phone: _____ Ext: _____ Claim#: _____

Medpay Insurance (usually the company of the car you are in or your own policy)

Insurance Company Name: _____ Adjuster Name: _____

Phone: _____ Ext: _____ Claim#: _____

Medpay limit amount: $_____

Do you have a copy of the accident report? No____ Yes ____ (please provide a copy)

By signing below, I verify that the above information is true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Keefer CHIROPRACTIC Trusted Care
521 Yopp Rd. Ste 107
Jacksonville, NC 28540
Phone: 910-333-9723 Fax: 910-333-8454

Pt. Name: _____

Acct #: _____

Neck Index

Pain Intensity
- 0- I have no pain at the moment.
- 1- The pain is very mild at the moment.
- 2- The pain comes and goes and is moderate.
- 3- The pain is fairly severe at the moment.
- 4- The pain is very severe at the moment.
- 5- The pain is the worst imaginable at the moment.

Personal Care
- 0- I can look after myself with no extra pain.
- 1- I can look after myself, but it causes extra pain.
- 2- It is painful to look after myself, and I am slow and careful.
- 3- I need some help, but I manage most of my care.
- 4- I need help every day in most aspects of self-care.

Sleeping
- 0- I have no trouble sleeping.
- 1- My sleep is slightly disturbed. (less than 1hr sleepless)
- 2- My sleep is mildly disturbed. (1-2 hrs sleepless)
- 3- My sleep is moderately disturbed. (2-3 hrs sleepless)
- 4- My sleep is greatly disturbed. (3-5 hrs sleepless)
- 5- My sleep is completely disturbed. (5-7 hrs sleepless)

Lifting
- 0- I can lift heavy weights without extra pain.
- 1- I can lift heavy weights, but it causes some pain.
- 2- Pain prevents me from lifting heavy weight from the floor, but I can manage if they are conveniently positioned.
- 3- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- 4- I can only lift very light weights.
- 5- I cannot lift or carry anything at all.

Reading
- 0- I can read as much as I want with no neck pain.
- 1- I can read as much as I want with slight neck pain.
- 2- I can read as much as I want with moderate neck pain.
- 3- I cannot read as much as I want because of moderate neck pain.
- 4- I can hardly read at all because of severe neck pain.
- 5- I cannot read at all because of neck pain.

Driving
- 0- I can drive my car without any neck pain.
- 1- I can drive my car as long as I want with slight neck pain.
- 2- I can drive my car as long as I want with moderate neck pain.
- 3- I cannot drive my car as long as I want because of moderate neck pain.
- 4- I can hardly drive at all because of severe neck pain.
- 5- I cannot drive my car at all because of neck pain.

Concentration
- 0- I can concentrate fully when I want with no difficulty.
- 1- I can concentrate fully when I want with slight difficulty.
- 2- I have a fair degree of difficulty concentrating when I want.
- 3- I have a lot of difficulty concentrating when I want.
- 4- I have a great deal of difficulty concentrating when I want.
- 5- I cannot concentrate at all.

Recreation
- 0- I am able to engage in all my recreation activities without neck pain.
- 1- I am able to engage in all my usual recreation activities with some neck pain.
- 2- I am able to engage in most but not all my usual recreation activities because of neck pain.
- 3- I am only able to engage in a few of my usual recreation activities because of neck pain.
- 4- I can hardly do any recreation activities because of neck pain.
- 5- I cannot do any recreation activities at all.

Work
- 0- I can do as much work as I want.
- 1- I can only do my usual work but no more.
- 2- I can only do most of my usual work but no more.
- 3- I cannot do my usual work.
- 4- I can hardly do any work at all.
- 5- I cannot do any work at all.

Headaches
- 0- I have no headaches at all.
- 1- I have slight headaches, which come infrequently.
- 2- I have moderate headaches, which come infrequently.
- 3- I have moderate headaches, which come frequently.
- 4- I have severe headaches, which com frequently.
- 5- I have headaches almost all the time.

Patient Signature: _____ Doctor Signature: _____ Date: _____

Keefer CHIROPRACTIC Trusted Care
521 Yopp Rd. Ste 107
Jacksonville, NC 28540
Phone: 910-333-9723 Fax: 910-333-8454

Pt. Name: _____

Acct #: _____

Back Index

PAIN INTENSITY

0- The pain comes and goes and is very mild.
1- The pain is mild and does not vary much.
2- The pain comes and goes and is moderate.
3- The pain is moderate and does not vary much.
4- The pain comes and goes and is severe.
5- The pain is severe and does not vary much.

PERSONAL CARE

0- I would not have to change my way of washing or dressing in order to avoid pain.
1- I do not normally change my way of washing or dressing even though it causes some pain.
2- Washing and dressing increases the pain, but I manage not to change my way of doing it.
3- Washing and dressing increases the pain, and I find it necessary to change my way of doing it.
4- Because of the pain, I am unable to do some washing and dressing without help.
5- Because of the pain, I am unable to do any washing or dressing without help.

LIFTING

0- I can lift heavy weights without extra pain.
1- I can lift heavy weights, but it causes extra pain.
2- Pain prevents me from lifting heavy weights off the floor.
3- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned. (e.g., on a table)
4- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5- I can only lift very light weights at the most.

WALKING

0- Pain does not prevent me from walking any distance.
1- I have some pain while walking but it doesn't increase with distance.
2- I cannot walk for more than 1 mile without increasing pain.
3- I cannot walk for more than 1/2 mile without increasing pain.
4- I cannot walk for more than 1/4 mile without increasing pain.
5- I cannot walk at all without increasing pain.

SITTING

0- I can sit in any chair as long as I like without pain.
1- I can only sit in my favorite chair as long as I like.
2- Pain prevents me from sitting more than 1 hour.
3- Pain prevents me from sitting more than ½ hour.
4- Pain prevents me from sitting more than 10 minutes.
5- I avoid sitting because it increases my pain immediately.

STANDING

0- I can stand as long as I want without pain.
1- I have some pain while standing, but it does not increase with time.
2- I cannot stand for longer than 1 hour without increasing pain.
3- I cannot stand for longer than ½ hour without increasing pain.
4- I cannot stand for longer than 10 minutes without increasing pain.
5- I avoid standing; because it increases the pain immediately.

SLEEPING

0- I get no pain in bed.
1- I get pain in bed, but it does not prevent me from sleeping well.
2- Because of pain, my normal night's sleep is reduced by less than 25%.
3- Because of pain, my normal night's sleep is reduced by less than 50%.
4- Because of pain, my normal night's sleep is reduced by less than 75%.
5- Pain prevents me from sleeping at all.

SOCIAL LIFE

0- My social life is normal and gives me no pain.
1- My social life is normal, but increases the degree of my pain.
2- Pain has no significant effect on my social life apart from limiting my more energetic interests. (e.g., dancing, etc.)
3- Pain has restricted my social life, and I do not go out very often.
4- Pain has restricted my social life to my home.
5- I have hardly any social life because of the pain.

TRAVELING

0- I get no pain while traveling.
1- I get some pain while traveling, but none of my usual forms of travel make it any worse.
2- I get extra pain while traveling, but it does not cause me to seek alternative forms of travel.
3- I get extra pain while traveling which compels me to seek alternative forms of travel.
4- Pain restricts all forms of travel except that done while lying down
5- Pain prevents all forms of travel.

CHANGING DEGREE OF PAIN

0- My pain is rapidly getting better.
1- My pain fluctuates, but overall is definitely getting better.
2- My pain seems to be getting better, but improvement is slow at present.
3- My pain is neither getting better nor worse.
4- My pain is gradually worsening.
5- My pain is rapidly worsening.

Patient Signature: _____ Doctor Signature: _____ Date: _____