Peak Performance
CHIROPRACTIC

Name _____ Phone (____)_____ DOB ____/_____/_____

Age _____ Height _____ Weight _____ Sex M / F S/S # _____

Address _____ City _____ State _____ Zip _____

Employer's Name _____ Employers Address _____

Your Ins. Co _____ Policy # _____ Agent's Name: _____

Name on Policy (if other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

ATTORNEY:

Name _____ _____ Phone (_____)_____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ( ) Yes ( ) No Name(s) _____

Nature of Accident:

1. Date of Accident _____/_____/_____ Time of Day: _____ AM/PM
2. Were you: ( )Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing a seat belt? ( )Yes ( )No
4. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
5. Name of the street? _____
6. What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West
7. Name of the street? _____
8. Were you struck from: ( ) Behind ( )Front ( ) Left side ( ) Right Side
9. Approximate speed of your car : _____mph Other car's speed: _____ mph
10. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
11. Were the police notified? ( ) Yes ( )No
12. In your own words, please describe accident: _____
    _____
    _____
    _____
13. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe:
    _____
    _____
14. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____

13. What are your PRESENT complaints and symptoms? _____

_____

_____

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe:

_____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:

_____

16. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. _____

_____

_____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address: _____

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arm	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms other than above _____

21. Have you lost time form work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question.

A. Last Day Worked: _____

B. Type of Employment: _____

C. Present Salary: _____

D. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe, in detail:

_____

_____

_____

23. Other pertinent information: _____

_____

_____

_____

_____ _____

Date Patient's Signature

Peak Performance
CHIROPRACTIC

Neck Index

Patient Name: _____ **Date:** _____

Section 1 – Pain Intensity

0 ☐ I have no pain at the moment.
1 ☐ The pain is very mild at the moment.
2 ☐ The pain is moderate at the moment.
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.

Section 2- Personal Care (Washing, Dressing, etc.)

0 ☐ I can look after myself normally, without causing extra Pain.
1 ☐ I can look after myself normally, 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 manage most of my personal care.
4 ☐ I need help every day in most aspects of self care.
5 ☐ I do not get dressed; I wash with difficulty and stay in bed.

Section 3- Lifting

0 ☐ I can lift heavy weights without extra pain.
1 ☐ I can lift heavy weights, but it gives extra pain.
2 ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
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 lift very light weights
5 ☐ I cannot lift or carry anything at all

Section 4- Reading

0 ☐ I can read as much as I want to, with no pain in my neck.
1 ☐ I can read as much as I want to, with slight pain in my neck.
2 ☐ I can read as much as I want to, with moderate pain in my neck.
3 ☐ I can't read as much as I want, because of moderate pain in my neck.
4 ☐ I can hardly read at all, because of severe pain in my neck.
5 ☐ I cannot read at all.

Section 5- Headaches

0 ☐ I have no headaches at all
2 ☐ I have moderate headaches that come infrequently.
3 ☐ I have moderate headaches that come frequently.
4 ☐ I have severe headaches that come frequently.
5 ☐ I have headaches almost all the time.

Section 6 – Concentration

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

Section 7- Work

0 ☐ I can do as much work as I want to.
1 ☐ I can do my usual work, but no more.
2 ☐ I cannot do my usual work.
3 ☐ I can hardly do any work at all.
4 ☐ I can't do any work at all.

Section 8- Driving

0 ☐ I can drive my car without any neck pain.
1 ☐ I can drive my car as long as I want, with slight pain in my neck.
2 ☐ I can drive my car as long as I want, with moderate pain in my neck.
3 ☐ I can't drive my car as long as I want, because of moderate pain in my neck.
4 ☐ I can hardly drive at all, because of severe pain in my neck.
5 ☐ I can't drive my car at all.

Section 9- Sleeping

0 ☐ I have no trouble sleeping.
1 ☐ My sleep is slightly disturbed (less than 1 hr 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)

Section 10- Recreation

0 ☐ I am able to engage in all my recreation activities
1 ☐ I am able to engage in all my recreation activities, with some neck pain.
2 ☐ I am able to engage in most, but not all of my usual recreation activities, because of my neck pain.
3 ☐ I am able to engage in a few of my recreation activities, because of pain in my neck.
4 ☐ I can hardly do any recreation activities
5 ☐ I can't do any recreation activities at all

Peak Performance
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Low Back Index

Patient's Name: _____ **Date:** _____

This questionnaire gives your doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the on box which applies to you.

Section 1 Personal Care (washing, dressing, etc.)

0☐ I can look after myself normally without causing 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 manage most of my personal care.
4☐ I need help everyday in most aspects of self care.
5☐ I do not get dressed, wash with difficulty and stay in bed.

Section 2 Lifting

0☐ I can lift heavy objects without extra pain.
1☐ I can lift heavy objects but it gives me extra pain.
2☐ Pain prevents me from lifting heavy objects off the floor, but I can manage if they are positioned on a table.
3☐ Pain prevents me from lifting heavy objects, but I can manage light to medium objects if they are on a table.
4☐ I can only lift very light objects.
5☐ I cannot lift or carry anything at all.

Section 3 Walking

0☐ Pain does not prevent me from walking any distance.
1☐ Pain prevents me from walking for more than one hour.
2☐ Pain prevents me from walking for more than 30 minutes.
3☐ Pain prevents me from walking for more than 10 minutes.
4☐ I can only walk a few steps.
5☐ I can't walk any distance without increased pain.

Section 4 Sitting

0☐ I can sit in any chair as long as I like it.
1☐ I can only sit in my favorite chair for as long as I like it.
2☐ Pain prevents me from sitting for more than an hour.
3☐ Pain prevents me from sitting for more than 30 minutes.
4☐ Pain prevents me from sitting for more than 10 minutes.
5☐ Pain prevents me from sitting at all.

Section 5 Standing

0☐ I can stand as long as I want without extra pain.
1☐ I can stand as long as I want but it gives me extra pain.
2☐ Pain prevents me from standing for more than an hour.
3☐ Pain prevents me from standing for more than 30 minutes.
4☐ Pain prevents me from standing for more than 10 minutes.
5☐ Pain prevents me from standing at all.

Section 6 Sleeping

0☐ I sleep well
1☐ Pain occasionally interrupts my sleep.
2☐ Pain interrupts my sleep half of the time.
3☐ Pain often interrupts my sleep.
4☐ Pain always interrupts my sleep.
5☐ I never sleep very well.

Section 7 Pain Intensity

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

Section 8 Social Life

0☐ My social life and recreational life is unchanged.
1☐ My social life and recreational life is unchanged but Increases pain.
2☐ My social life and recreational life is unchanged but Severely increases pain.
3☐ Pain has restricted my social and recreational life.
4☐ Pain has severely restricted my social and recreational life.
5☐ I have no social life because of pain.

Section 9 Traveling

0☐ I can travel anywhere without extra pain.
1☐ I can travel anywhere but it gives me extra pain.
2☐ Pain is bad but I can manage traveling over two hours.
3☐ Pain restricts me to trips of less than an hour.
4☐ Pain restricts me to trips less than 30 minutes.
5☐ Pain prevents me from traveling/

Section 10 Changing Degree of Pain

0☐ My pain is rapidly getting better.
1☐ My pain fluctuates but is definitely getting better
2☐ My pain seems to be getting better but the improvement Is slow.
3☐ My pain is neither getting better nor worse.
4☐ My pain is gradually getting worse.
5☐ My pain is rapidly getting worse.