Goodyear
Chiropractic
11 W. Van Buren Avondale, AZ 85323
(623)932.4060 (623)932.4417 fax

Functional Questionnaire

General Pain Intensity

0	2	4	6	8	10
No pain	mild annoying	restricts activities	moderate restrictions	unable to do average activities	severe restrictions

Work Ability

0	2	4	6	8	10
I have no restrictions	regular work w/ annoying pain	some restricts 75% productive	restricted 50% productive	significant restrictions 25% productive	can not work

Sleep

0	2	4	6	8	10
Normal Sleep pattern	occasional disturbance	lose 1 hour per night	lose 3 hours per night medication helps	50% sleep loss need meds to sleep	< 2-3 hours sleep/night

Social & Recreation

0	2	4	6	8	10
I have no restrictions	my pain slows me down	pain restricts some activities	I do not go out as often	significant limitations	unable to participate at all

Travel

0	2	4	6	8	10
No pain on long trips	mild pain on long trips	moderate pain on long trips	moderate on short trips	severe pain on long trips	severe pain on short trips

Personal Care

0	2	4	6	8	10
no pain no restriction	mild pain no restriction	moderate pain need to go slowly	sometimes requires assistance	unable to do average activities	severe pain/ requires assist.

Mental & Psychological

0	2	4	6	8	10
Normal no anxiety	mild difficulty concentrating	difficulty w/ complex tasks	easily agitated anxiety w/ driving	difficult to focus avoid going out	severe memory loss/ anxiety

Neck, Upper Back, Arm Function (Lifting, Typing, Neck Motion...)

0	2	4	6	8	10
no pain no restriction	annoying pain w/ heavy use	moderate use aggravates pain	can not carry heavy objects	unable to hold grasp object	pain with any use

Low Back, Hip, Leg (Lifting, Sitting, Standing...)

0	2	4	6	8	10
no pain no restriction	annoying after prolonged activity	increased pain w/ heavy activity	increased pain w/ moderate activity	increased pain w/ light activity	pain with any use

Headache

0	2	4	6	8	10
no headaches	mild annoyance	prevents participation in some activities	lose 2 hours/day of productivity	unable to do average activities	cant do anything

Patient Signature_____ Date_____ File Number_____ Total Score_____

Goodyear Chiropractic
11 W. Van Buren St., Ste.28
Avondale, AZ 85323

Auto Accident Questionnaire

1. **Check which vehicle-type you were in.**
   Car____ Truck____ Van____ SUV___ Bus____
   Compact____ Mid-size____ Full-size____ Light____

2. **Check where you were in the vehicle.**
   Driver_____ Front Passenger _____
   Rear Passenger: Right_____ Left_____ Middle____

3. **Was your vehicle stopped?** No_____ Yes_____
   If yes, why was it stopped?
   Traffic Light_____ Intersection_____ Stop sign_____
   Traffic_____ Pedestrian_____ Parked_____
   Other_____

4. **Was your vehicle slowing down?** No____Yes____
   If yes, why was it slowing?
   Traffic Light_____ Intersection_____ Stop sign_____
   Traffic_____ Pedestrian_____ Parked____
   Turning_____ Other_____

5. **What damage did your vehicle sustain?**
   Minimal____Moderate____Extensive____Totaled___
   Unsure_____ Other_____

6. **Was there another car involved in the accident?**
   No_____ Yes_____ If yes, what type?
   Car_____Truck_____Van_____SUV_____ Bus____
   Compact_____Mid-size_____Full-size_____Light___

7. **How did this vehicle strike the car you were in?**
   Head On_____ From Right_____ From Left____
   Rear Ended_____ Side Swiped on Right_____
   Side Swiped on Left_____ Other_____

8. **How badly was this other car damaged?**
   Minimal____Moderate____Extensive___Totaled____
   Unsure_____ Other_____

9. **Was there a third vehicle involved in the accident?**
   No_____ Yes_____ If yes, what type?
   Car_____Truck_____Van_____SUV_____ Bus___
   Compact____ Mid-size____ Full-size_____Light____

10. **How did this vehicle strike the car you were in?**
    Head On_____ From Right_____ From Left_____
    Rear Ended_____ Side Swiped on Right_____
    Side Swiped on Left_____ Other_____

11. **How badly was this third vehicle damaged?**
    Minimal____Moderate____Extensive____Totaled___
    Unsure_____ Other_____

12. **Did any other vehicles strike your car?**

    _____

13. **What were the conditions at the time of the accident?**
    Time: Day____ Dawn____ Dusk____ Night____
    Road: Dry____ Wet____ Snow____ Ice____
    Visibility: Good____ Fair____ Poor____ Other___
    Other Factors: Sun light____ Dark____ Rain___
    Snow____ Fog____ Traffic____ Other_____

14. **Were you prepared for the impact?**
    Surprised_____ Aware_____ And Brace_____

15. **Was your foot on the brake when you were hit?**
    No___ Yes___ But then knocked off the pedal_____

16. **What type of seat belt were you wearing?**
    Shoulder-lap____ Lap____ Shoulder____ None___

17. **Where was you headrest?**
    High____ Low____ Middle____ No headrest____

18. **Did your air bags deploy?**
    Yes_____ No_____ Car had no airbags_____

19. **Position your body was in at the time of impact?**
    Straight____ Slouched____ Rotated:Left___Right___

20. **What direction was your body thrown?**
    Back then forward_____ Forward then back_____
    Sideways___ Across vehicle____Outside vehicle___
    Don't recall____ Other_____

21. **Position your head was in at the time of impact?**
    Straight____ Rotated: Left____ Right____ Other____

22. **What motion was your head and neck sent into?**
    Back then forward_____ Forward then back_____
    Sideways_____ Don't recall_____ Other_____

23. **Connect the body part with the object it hit.**

Head	Steering Wheel
Right Arm	Dash Board
Left Arm	Windshield
Chest	Right Side Door
Right Leg	Left Side Door
	Right Window
	Left Window
_____	Headrest
Other Body Part	Ceiling
	Other_____

24. **Additional Information?**

    _____

    _____

Patient (Guardian) Signature_____ Date_____ File Number_____

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Insurance Information

Date of Accident: _____ _____**Driver** _____**Passenger**

Please provide as much information as possible so your case can be set up to your financial advantage. In the state of Arizona, insurance laws read that you have the right to bill any insurance policy under which you have coverage. In the case of more than one insurance coverage, overpayment occurs. We only need to be paid once, so all overpayments will be reimbursed.

Health Insurance

Insured Name: _____
Insurance Company: _____
Phone: _____
ID# _____
Group# _____
Send Claims To: _____

I give permission for Goodyear Chiropractic to bill my Health Ins. ____*Yes*____*No*

Medical Payment Coverage: On your automobile insurance or the automobile insurance for the car in which you were a passenger, there may be coverage called "Med Pay". This coverage is for any injuries that may have occurred to someone in the automobile. It will cover anything from an automobile accident that either was or was not your fault, to slamming your finger in the car door. Using this portion of the policy cannot raise your premium or affect your record in anyway. In fact, this is exactly why you pay for "Med Pay" on your insurance policy. (This information is printed on the "Proof of Insurance" card in automobile.

Claimant: _____
Policy Holders Name: _____
Insurance Company: _____
Phone# _____ Ext # _____
Policy # _____
Claim # _____
Adjuster: _____
Send Claims To: _____

I give permission for Goodyear Chiropractic to bill my Auto Ins/MedPay/PIP. ____*Yes*____*No*

Third Party Liability: Insurance information for the person who was in the "Other Car", found on the accident report.

Accident Report: _____
Was Anyone Ticketed? _____YES _____NO WHO: _____
Driver's Name: _____
Policy Holder's Name: _____
Insurance Co. Name: _____
Phone # _____ Ext # _____
Policy # _____
Claim # _____
Adjuster: _____
Send Claims To: _____

I give permission for Goodyear Chiropractic to bill my Third Party. ____*Yes*____*No*

Attorney Information:

Name: _____
Firm: _____
Contact Person: _____
Phone # _____ Ext # _____
Send Statement To: _____

Patient Name _____ Medical Record # _____