

WELCOME TO DI SIENA FAMILY CHIROPRACTIC: INSPIRED CENTRE FOR WELLNESS

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PERSONAL INJURY PATIENT QUESTIONNAIRE

Dear Patient:

It is important in a personal injury case to establish a complete and accurate base of personal and historical information. Along with the objective examination findings, this information often becomes a critical part of the decision making process in coming to final determination or conclusions about your case. Therefore, *your help and cooperation in answering this questionnaire as completely and accurately as possible is necessary and appreciated*

GENERAL INFORMATION

Patient Information

Name: _____ Age: _____ Date: _____

Address: (complete mailing address) _____

City: _____ State: _____ Zip: _____

Phone No.: (____) _____ E-Mail: _____

Date of Birth: _____ Soc Sec. No.: _____ Driver's Lic. No.: _____

Marital Status: Single Married Divorced Widowed

Male Female * Right Handed Left Handed Both * Height: _____ Weight: _____

Employer: _____ Work Phone No.: (____) _____

Occupation: _____ Work E-Mail: _____

Give a brief description of job duties: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone No.: _____

Your Health Insurance Carrier Information:

Name: _____ Phone No.: (____) _____

Address: _____

Policy No.: _____ Claims Representative: _____ Claim No.: _____

Your Auto Insurance Carrier Information:

Name: _____ Phone No.: (____) _____

Address: _____

Policy No.: _____ Claims Representative: _____ Claim No.: _____

Driver/Other Vehicle Auto Insurance Carrier Information:

Name: _____ Phone No.: (____) _____

Address: _____

Policy No.: _____ Claims Representative: _____ Claim No.: _____

Attorney Information:

Have you retained an attorney? YES NO

Name: _____ Phone No.: (____) _____

Address: _____

HISTORY / NATURE OF THE ACCIDENT / INJURY

Information About Your Accident / Injury:

In your own words, please describe the accident: _____

- Date of accident / injury: _____
- Time of the accident / injury occurred: _____ A.M. _____ P.M.
- Were you: Driver
 Passenger (check all that apply):
 Front Seat Back Seat Left Side Middle Right Side
- Number of vehicles involved: _____
- Number of people: in your vehicle: _____ in other vehicle(s): _____
- Names of people in your vehicle:
 - _____
 - _____
 - _____
 - _____
- Type of vehicles: Yours: _____ Other vehicle: _____
- Type of transmission: Automatic Manual (please circle if you were in neutral or a gear)
- Direction you were headed: N S E W
On (name of street): _____
- Direction the other vehicle headed? N S E W
On (name of street): _____
- Your car was struck from: Behind Front Left side Right side
 Left side-swipe Right side-swipe
- During and after the collision, your vehicle: kept going straight, not hitting anything
 kept going straight, hitting car in front was hit by another vehicle
 spun around, not hitting anything spun around, hitting another car
 spun around, hitting object other than car
 other: _____

- Was the vehicle drivable after the accident? YES NO
- Check if any of the following vehicle parts broke, bent or were damaged in your car:
 windshield steering wheel dash seat frame mirror
 knee bolster / glove department other: _____
- Road condition: Wet Dry
- Wearing your seat belt? YES, Type: Lap Shoulder 3 Point NO
- Does your vehicle have a headrest? YES, Position of the head rest was:
 level with shoulders lower neck base of head middle of head top of head
 above the head NO
- Airbags: YES NO, Did the airbags deploy? YES NO
- At the time of impact was your car: stopped completely slowing down
 moving forward at a steady speed gaining speed other, please explain: _____

- Estimated speed of your vehicle: _____ M.P.H.
- At the time of impact was the other car: stopped completely slowing down
 moving forward at a steady speed gaining speed other, please explain: _____

- Estimated speed of other vehicle: _____ M.P.H.
- Were you: aware & prepared for the impact surprised & unprepared?
- Was your foot depressed on the brake pedal? YES NO
- Head position (**check all that apply**): looking forward left right up down
 looking over shoulder
- Body position: leaning against door frame leaning against arm rest neutral position
- Hand position: forcefully braced on steering wheel left hand at o'clock
 right hand at o'clock left hand not on steering wheel right hand not on steering wheel
- How did your head move (**check all that apply**): forward/flexion backward/extension
 sideways left sideways right
- How did your body move (**check all that apply**): forward backwards sideways left
 sideways right
- Did your head or body strike anything inside the vehicle? YES NO, if yes, what body part (face, head, shoulder, chest, knee...) hit what vehicle object (steering wheel, dashboard, windshield, seatbelt, door frame, head rest, roof, other...)_____

- Did any objects fly around the vehicle during the impact? ___ YES ___ NO, if yes, what? _____

- Were you bleeding or bruised as the result of the injury? ___ YES ___ NO, if yes, where? _____

- Were you knocked unconscious? ___ YES ___ NO, if yes, for how long? _____
- What was the last thing you remember happening in the accident? _____

• Were the police notified? ___ YES ___ NO, Was a report made? ___ YES ___ NO

• **Please describe any symptoms you felt:**

A. IMMEDIATELY AFTER the accident: _____

B. LATER THAT DAY / EVENING: _____

C. THE NEXT DAY: _____

CURRENT SYMPTOMS:

RATE THE SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:
(RATE ON A SCALE OF 1-10, 1=ANNOYANCE, 10=SEVERE, 0= DO NOT HAVE THE SYMPTOM)

Headache	Fainting	Loss of Taste
<i>Neck pain</i>	<i>Nausea</i>	Chest Pain
Neck Stiffness	<i>Vomiting</i>	Shortness of Breath
Head Seem Too Heavy	Ears Ring	Flushed Face
Jaw Pain	Buzzing in Ears	Hands Cold
<i>Shoulder Pain</i>	Loss of Balance	Feet Cold
<i>Pins & Needles in Arms</i>	<i>Visual Disturbances</i>	Cold Sweats
<i>Numbness in Fingers</i>	Light Bothers Eyes	Fever
<i>Weakness in Arms</i>	Loss of Memory	Stomach Upset
Mid-Back Pain: upper/middle/lower	Nervousness	Diarrhea
Low Back Pain	Tension	Constipation
Low Back Stiffness	Irritability	Others:
Pins and Needles in Legs	Sleeping Problems	
Numbness in Toes	Fatigue	
<i>Weakness in Legs</i>	Difficulty Swallowing	
Dizziness	Loss of Smell	

- Before this injury, how would you describe you health? ___ Excellent ___ Good ___ Fair
___ Poor, If 'Fair' or 'Poor', please explain: _____

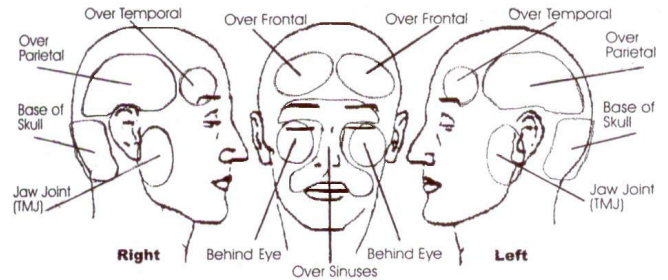
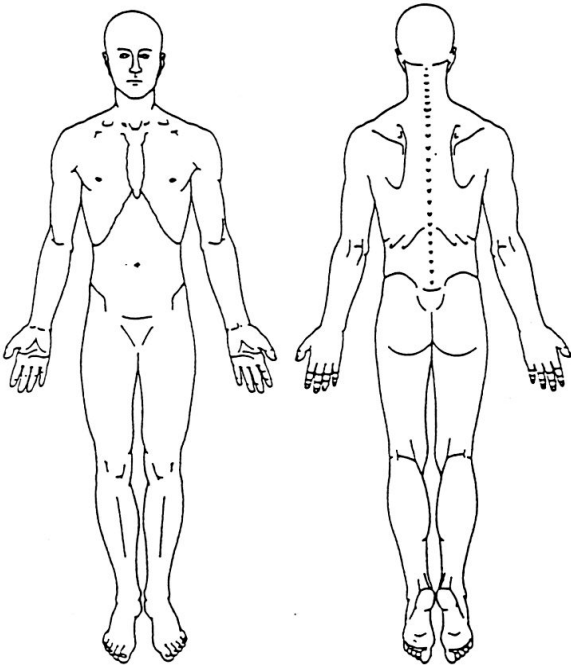
- Did you have any of these complaints prior to the accident? ___ YES ___ NO, **if yes, please circle the above rated symptoms.**
- Which circled complaints that you had prior to the accident worsened due to the accident? _____

- Since the injury occurred, are your symptoms: ___ Improving ___ Getting worse ___ Same
Please explain: _____

- Is there a time of day that you feel worse? ___ YES ___ NO, if yes, please explain: _____

Mark the areas on your body and/or head where you are having symptoms from your injury(ies) with the appropriate letter (P, N, T, B, R,S). Also, review the Pain Scale on the bottom of the page and rate the areas of pain with the appropriate number from scale. Please individually mark the Duration of each symptom (see scale below).

P = Pain **N** = Numbness/Tingling **T** = Tenderness **B** = Burning **R** = Radiating **S** = Stiffness



PAIN SCALE

0	=	None	= No Pain
1-3	=	Mild	= The pain is an annoyance but does not stop me from work, home or sorts activities. Dull soreness, achy, stiffness
4-7	=	Moderate	= The pain causes a marked handicap in my ability to function, I can perform activities at work, home or sports, but it takes longer or I need to take breaks. Hurting pain, very sore, limited motion
8-10	=	Severe	= The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity. Sharp pain, stabbing pain, jabbing pain, very limited motion

DURATION (Please circle one): **Occasional** = [25% of the day] **Intermittent** = [25%-50% of the day]
Frequent = [50%-75% of the day] **Constant** = [75%-100% of the day]

Relieving factors: Rest / Exercise / Bracing / Taping / Sitting / Standing / Lying on back / Heat / Cold Pack

Other: _____

Aggravating Factors: Cough / Sneeze / Bowel Movement / Lifting / Bending / Push / Pull / Driving / Lying on back / Sitting / Walking / Running / Standing / Changing body positions

Other: _____

HISTORY OF TREATMENT:

INITIALLY

- Did the paramedics come? ___ YES ___ NO, Did they check you? ___ YES ___ NO
- Did you go to a hospital / emergency room? ___ YES ___ NO, **If yes**, answer the following questions below. **If no**, go to the post accident questions to continue filling out questionnaire.
- Name of hospital / ER: _____ City: _____
- Were you admitted to the hospital? ___ YES ___ NO, if yes, how long? _____
- Name of doctor(s) at the hospital / ER who treated you? _____
- Describe the type of treatment or diagnostic testing that was done: _____

- What did the hospital doctor(s) say was wrong with you? _____

- Were you told that you would need more treatment? ___ YES ___ NO, if yes, explain: _____

- Did the doctor(s) restrict or modify your work / home activities? ___ YES ___ NO, if yes, how? _____

POST ACCIDENT

- Did you seek treatment on your own? ___ YES ___ NO
- When did you first seek treatment for your injury? Date: _____
- If you did not see a doctor for the first time within the first month, indicate why: ___ No pain was noticed
___ No transportation ___ No appointment schedule available
___ Work / home schedule conflicts ___ I thought the pain would go away
- In the last month your condition has: ___ Stayed the same ___ Improved ___ Worsened
___ Fluctuated, but overall has stayed about the same
- If your condition has worsened, please explain: _____

- If your condition continues to improve, please explain: _____

Please list **ALL** doctors you have seen since your injury. (Please list them in the order you saw them):

Name of the doctor/facility #1: _____ City/location: _____ Date: _____

- Type of doctor (degree or specialty): _____
- Describe treatment (Medications, physical therapy...) and/or tests (X-rays, MRI...): _____

- What did this doctor say was wrong with you? _____
- Date when treatment started: _____ Date when treatment stopped: _____
- How many treatments/visits were there? _____ How long were the treatments? _____
- What was the result/outcome of the treatment? _____
- Still treating with this doctor? ___ YES ___ NO, if yes, how often? _____
- Did this doctor take you off work? ___ YES ___ NO, if yes, give dates: _____
- Did this doctor restrict or modify your work activities? ___ YES ___ NO, if yes, how?: _____
- Did this doctor say you would need more treatment? ___ YES ___ NO, if yes, explain: _____
- Did this doctor refer you anywhere else? ___ YES ___ NO, if yes, where and why? _____

Name of the doctor/facility #2: _____ City/location: _____ Date: _____

- Type of doctor (degree or specialty): _____
- Describe treatment (Medications, physical therapy...) and/or tests (X-rays, MRI...): _____

- What did this doctor say was wrong with you? _____
- Date when treatment started: _____ Date when treatment stopped: _____
- How many treatments/visits were there? _____ How long were the treatments? _____
- What was the result/outcome of the treatment? _____
- Still treating with this doctor? ___ YES ___ NO, if yes, how often? _____
- Did this doctor take you off work? ___ YES ___ NO, if yes, give dates: _____
- Did this doctor restrict or modify your work activities? ___ YES ___ NO, if yes, how?: _____
- Did this doctor say you would need more treatment? ___ YES ___ NO, if yes, explain: _____
- Did this doctor refer you anywhere else? ___ YES ___ NO, if yes, where and why? _____

- Were any other tests, examinations, treatments, or therapy done that were not described above? ___ YES ___ NO, if yes, please describe what was done and what the results were: _____

- Are you currently taking medication to relieve the effects of this injury? ___ YES ___ NO, if yes, please describe what you take, (prescription or non-prescription), how much it helps, how often you take it, etc.:

- Are you currently using a brace, support, crane, crutch(es), wheelchair, TENS unit, or other aid because of the effects of this injury? ___ YES ___ NO, if yes, please describe type and how often it is used: _____

- What treatment(s) offer you the most relief, and how long do the benefits last? _____

- Have there been any recommendations for diagnostic testing or treatment that you have not received? ___ YES ___ NO, if yes, what was recommended, and who recommended it? _____

RESTRICTIONS:

Have you lost time from work as a result of this accident? ___ YES ___ NO, **if yes, please complete the following:**

- Last day worked: _____
- A. Returned to work: _____
- B. Place of employment: _____ Job description: _____
- C. Present salary: _____
- D. Are you being compensated for lost time from work? ___ YES ___ NO, **if yes, please state type of compensation you are receiving:** _____

- Do you exercise? YES NO, **if yes, please describe type & frequency:** _____

- Are there any restrictions to your exercising since the accident? YES NO, **if yes, please describe:**

- Do you participate in any sports activities? YES NO, **if yes, describe type & frequency:**

- Are there any restrictions to your sport activity since the accident? YES NO, **if yes, please describe:** _____

- Do you have any hobbies? YES NO, **if yes, please describe type & frequency:** _____

- Are there any restrictions to your hobbies since the accident? YES NO, **if yes, please describe:**

- Since the accident are you able to perform your normal school activities (i.e. studying, reading, attending class)? YES NO, **if no, please explain what you cannot do & why:** _____

- Since the accident are you able to perform your normal / regular household chores / activities?
 YES NO, **if no, please explain what you cannot do & why:** _____

- Since the accident are you able to perform your normal / regular work activities? YES NO, **if no, please explain what you cannot do & why:** _____

PAST MEDICAL HISTORY:

PRIOR INJURIES:

- Have you ever had any **PRIOR INJURIES?** (e.g. sprains/strains, slips/falls, sport injuries, cumulative or repetitive traumas, etc.) YES NO, if yes, please explain: _____

- Have you been involved in any previous vehicle accidents? YES NO
- Please describe and give approximate dates of each accident:

1. Date: _____ Type of accident: _____
Treatment: _____ Symptoms Resolved? YES NO,
If no, please describe: _____

2. Date: _____ Type of accident: _____
Treatment: _____ Symptoms Resolved? YES NO,
If no, please describe: _____

3. Date: _____ Type of accident: _____
Treatment: _____ Symptoms Resolved? YES NO,
If no, please describe: _____

4. Date: _____ Type of accident: _____
Treatment: _____ Symptoms Resolved? YES NO,
If no, please describe: _____

- Do you have any congenial (from birth) factor that relate to this problem? YES NO, is yes, please describe: _____

- Do you have any previous illnesses that relate to this case? YES NO, if yes, please describe:

- Please describe any prior medical treatment: _____

- Please describe any prior chiropractic treatment: _____

FAMILY HISTORY

List any health problems in **your immediate family**: (Mother, Father, Brother, Sister) () Denied

Please list the information about your medical history in the sections below, **with the appropriate dates**. If a section does not apply to you, simply mark an (X) in the 'Denied' box:

Childhood illnesses: () Denied _____

Childhood injuries: () Denied _____

Allergies: () Denied _____

Present medications taken (i.e. birth control pill, prescriptions & over-the-counter): () Denied _____

Fractures: () Denied _____

Surgeries: () Denied _____

Hospitalizations: () Denied _____

Adult illnesses: () Denied _____

Arthritis: () Denied _____

REVIEW OF SYSTEMS:

Please list any problems (**not related to the accident**) that you **now have** with the following body systems:

Ears/Nose/Throat: () Denied _____

Eyes: () Denied _____

Lungs: () Denied _____

Liver: () Denied _____

G-1 tract (Stomach, intestines, Bowels, Etc.): () Denied _____

Kidney/Bladder: () Denied _____

Reproductive System: () Denied _____

Pregnant? Yes / No / Not Sure _____ Last Period? _____ / _____ / _____

Endocrine System: () Denied _____

Skin: () Denied _____

Neurological: () Denied _____

Heart/Circulation: () Denied _____

Psychological: () Denied _____

Injured Patient's Signature: _____ **Date:** _____

Parent/Guardian Signature (if minor) : _____ **Date:** _____

THANK YOU FOR YOUR TIME IN ACCURATELY COMPLETING THIS QUESTIONNAIRE!