Timothy Jameson, D.C. 22179 Redwood Rd., Castro Valley, CA 94546

Personal Injury Collision Questionnaire

Name: ____ Date:

The following series of questions are very important for the doctor understanding you and your case. Accurately answering the questions will better assist the doctor to diagnose your injuries, create a report of your condition(s) and make the best possible treatment recommendations. Please take the time to read and answer each question. If you do not understand a question ask the staff or place a question mark (?) on the area of your concern. Please circle or check off the answers where possible to save time.

How was your health prior to this incident? Excellent/Good/Fair/Poor

What was the date of your injury/collision? ____

Is there more than one case open currently? Yes No If yes, let the staff know now! ☐

Where did the collision happen? ____

____

____

Describe the collision in your own words: ____

____

____

____

What was your position in the car?

☐ Driver: ☐ Passenger: If passenger, were you sitting in: Front Right Middle Rear Left Other:

If you were not the driver what is the driver's name? ____

What were the road conditions at the time of impact? Dry/Damp/Wet/Raining/Snowy/Icy

How fast was **your vehicle** going at the time of impact? Stopped Why? Traffic ______________miles per hour.

I do not know. Were the brakes being applied at the time of impact? Yes No I do not know.

Did your vehicle strike another vehicle? Yes No Year: _______ Make: ______________Model: ______________

Was your vehicle struck by another vehicle? Yes No Year: _______ Make: ______________ Model: ______________

How fast was the **vehicle that struck** you going? ______________miles per hour. I do not know.

Direction of impact… 1st Collision: • Front • Back • Left • Right • Other Explain:

2nd Collision: • Front • Back • Left • Right • Other Explain:

3rd Collision • Front • Back • Left • Right • Other Explain:

Roll Over Yes No • Other Explain:

Were you wearing a seat belt across your lap? Yes No None available.

Were you wearing a shoulder seat belt across your chest/shoulder? Yes No None available.

Did you adequately brace for impact? Yes No I braced with my hands/feet. I was surprised at impact.

Which way was your body facing at impact • Straight ahead • Left • Right • Leaning Forward • Twisted

Did your body strike anything inside the vehicle at time of impact? Yes No If yes, What part of your body struck what part of the vehicle interior? i.e…(head/face chest chin shoulder stomach knee(s))

- Steering Wheel ______________________________ • Dashboard ______________________________
- Windshield ______________________________ • Roof ______________________________
- Left Side Door ______________________________ • Right Side Door ______________________________
- Left Side Window ______________________________ • Right Window ______________________________
- Other ______________________________

Did your seat back bend/break? Yes No

Where were you looking at the moment of impact? Straight ahead/Right/Left/Looking Up Down/Other:

I was seated in the car with good body position? Yes No If no, I was Leaning/Forward/Twisted/Bending/Other

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My hands were… 1 or both on the steering wheel/1 on the stick shift/1 or both in my lap/Other:
Did the Air Bag(s) deploy? Yes No If yes, were you struck by the air bag? Yes No
If yes, where were you hit? Face/Chest/Right Left Arm/Right Left hands/Other: ____________
Were you wearing glasses/sun glasses or a hat? Yes No
Were they still on after the crash? Yes No I do not know? If no, where were they found? ________
Is the vehicle you were in equipped with a trailer hitch? Yes No
Were there other occupants in the vehicle you were in? Yes No
If yes, how many others were in the vehicle? # 0 1 2 3 4 5 6. Were there any others in your vehicle injured? (Did anybody else in your vehicle go to emergency room or another doctor or chiropractic physician)?
If yes, how many others were injured? # 0 1 2 3 4 5 6
Immediately following the collision, how did you feel? ☐Dizzy/dazed ☐Disoriented ☐Nervous
☐Unconscious (how long?_______) ☐Nauseous ☐Upset ☐Weak ☐Shaky ☐Other ____________

Following the collision, what hurt? ☐None ☐Headache ☐Ringing in Ears ☐Blurry Vision ☐Jaw Pain
☐Neck pain ☐Trapezoids pains Right Left ☐Shoulder pains Right Left ☐Arm numbness/pains Right Left
☐Hand numbness/pains Right Left ☐Upper back pain ☐Lower back pain ☐Buttock pains/numbness Right Left
☐Thigh pains/numbness Right Left ☐Leg pains/numbness Right Left ☐Hip pains/numbness Right Left
☐Knee pains/numbness Right Left ☐Feet numbness/pains Right Left
How soon did the above symptoms or pains develop? ____________________

Generally how often do you currently have pain? • All of the time • Most of the time • A good bit of the time • Some of the time • A little of the time • Hardly any of the time • None of the time

Compared to how you felt immediately before to the collision what percent improved are you?

100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

Later following the collision, how did you feel? ☐Dizzy/dazed ☐Disoriented ☐Nervous ☐Nauseous
☐Weak ☐Shaky ☐Fatigue/Tired ☐Anxiety ☐Depression ☐Excessive irritability ☐Fear of driving
☐Loss of concentration ☐Jaw clenching ☐Grinding of teeth at night ☐Nightmares ☐Other: ________
☐Difficulty with sleeping at night
Additional or other current Symptoms/Complaints you have: ____________________

Do you feel your current listed symptoms are directly due to this crash? Yes No If no, please explain:

Is there any other reason you feel you are hurting other than this collision? Yes No If yes, please explain:

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Name: ______________________________ Date:

Following the crash did you go to hospital/Emergency Department/Urgent Care Facility Yes No
Were you admitted? Yes No If yes, how long? ______________________________

If yes, when? Immediately after the crash? Yes No • Next day • Other: ______________
How did you get to hospital? • Ambulance • Police Car • Private Transportation • Drove self
Name of Hospital Emergency Department/Urgent Care Facility: ______________________
Attended by Dr. ______________________________

What treatment/instructions at the hospital or urgent care facility did you receive?

☐None ☐Examined ☐Placed in a neck collar ☐Stitches or Bandaged (Where: ____________)
☐X-rayed Head/Neck/Back/Chest//Ribs/Right Left Shoulder/ Right Left Arm/ Right Left Wrist/ Right Left Hand/ Right Left Leg/ Right Left Hip/ Right Left Knee/ Right Left Ankle/ Right Left Foot
☐Scan MR/MRI/CT(CAT) Head/Brain/Neck/Back/Other: ______________________
☐Pain medication ☐Concussions ☐Given instructions regarding sprains & strains
☐Physical Therapy ☐Contact Chiropractic Physician ☐Contact Orthopedic Surgeon
☐Contact private physician ☐Referred to this office for treatment ☐Other: ____________

Have you seen any other doctor/health care provider as a result of this incident? Yes No If no go to page 6. If yes, list each:

1st Doctor's name: ______________________________
What is the health care provider specialty: Doctor of Chiropractic/Chiropractic Physician/Neurologist /Orthopedist/Family Practitioner/General Practitioner/Physical Therapist/Licensed Massage Therapist/Other:
____

When was your 1st visit (date)?
Who referred you to this health care provider? ______________________________
What test did this doctor/health care provider perform or order? ☐EMG ☐NCV ☐EKG

☐X-rays Head/Neck/Back/Chest//Ribs/Right Left Shoulder/Right Left Arm/Right Left Wrist/ Right Left Hand/Right Left Leg/Right Left Hip/Right Left Knee/Right Left Ankle/Right Left Foot
☐Scan MR/MRI/CT(CAT) Head/Brain/Neck/Back/Other: ______________________
☐Nuclear/Bone Scan

What did the doctor tell you was wrong/diagnosis? ______________________________
What treatment did the health care provider give to you? Adjustments/Physical Therapy/Home Rehabilitation Stretches Exercises/Medicines (Please list)/Surgery/Operation (Please List) ______________________
____

Are you currently seeing this health care provider? Yes No If yes, how often? ______________
Did the doctor/health care provider place you on any work restrictions? Yes No If yes, what type of restrictions Total Temporary Disability/ Temporary Partial Disability and how long? ______________
____

Did the doctor/health care provider care help you? Yes No Some Please Explain: ______________
Did the doctor/health care provider referred to anyone else? Yes No If yes, please list: ______________
____

Feel free to note any other important information about the doctor/ health care provider: ______________
____
____

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Personal Injury Collision Questionnaire

Name: ______________________________ Date:

2nd Doctor's name: ______________________________

What is the health care provider specialty: Doctor of Chiropractic/Chiropractic Physician/Neurologist /Orthopedist/Family Practitioner/General Practitioner/Physical Therapist/Licensed Massage Therapist/Other:

____

When was your 1st visit (date)?

Who referred you to this health care provider? ______________________________

What test did this doctor/health care provider perform or order? ☐EMG ☐NCV ☐EKG

☐X-rays Head/Neck/Back/Chest//Ribs/Right Left Shoulder/Right Left Arm/Right Left Wrist/ Right Left Hand/Right Left Leg/Right Left Hip/Right Left Knee/Right Left Ankle/Right Left Foot

☐Scan MR/MRI/CT(CAT) Head/Brain/Neck/Back/Other: ______________________________

☐Nuclear/Bone Scan

What did the doctor tell you was wrong/diagnosis? ______________________________

What treatment did the health care provider give to you? Adjustments/Physical Therapy/Home Rehabilitation Stretches Exercises/Medicines (Please list)/Surgery/Operation (Please List) ______________________________

____

Are you currently seeing this health care provider? Yes No If yes, how often? ______________________________

Did the doctor/health care provider place you on any work restrictions? Yes No If yes, what type of restrictions Total Temporary Disability/ Temporary Partial Disability and how long? ______________________________

____

Did the doctor/health care provider care help you? Yes No Some Please Explain: ______________________________

Did the doctor/health care provider referred to anyone else? Yes No If yes, please list: ______________________________

____

Feel free to note any other important information about the doctor/ health care provider: ______________________________

____

____

3rd Doctor's name ______________________________

What is the health care provider specialty: Doctor of Chiropractic/Chiropractic Physician/Neurologist /Orthopedist/Family Practitioner/General Practitioner/Physical Therapist/Licensed Massage Therapist/Other:

____

When was your 1st visit (date)?

Who referred you to this health care provider? ______________________________

What test did this doctor/health care provider perform or order? ☐EMG ☐NCV ☐EKG

☐X-rays Head/Neck/Back/Chest//Ribs/Right Left Shoulder/Right Left Arm/Right Left Wrist/ Right Left Hand/Right Left Leg/Right Left Hip/Right Left Knee/Right Left Ankle/Right Left Foot

☐Scan MR/MRI/CT(CAT) Head/Brain/Neck/Back/Other: ______________________________

☐Nuclear/Bone Scan

What did the doctor tell you was wrong/diagnosis? ______________________________

What treatment did the health care provider give to you? Adjustments/Physical Therapy/Home Rehabilitation Stretches Exercises/Medicines (Please list)/Surgery/Operation (Please List) ______________________________

____

Are you currently seeing this health care provider? Yes No If yes, how often? ______________________________

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Personal Injury Collision Questionnaire

Name: ______________________________ Date:

Did the doctor/health care provider place you on any work restrictions? Yes No If yes, what type of restrictions Total Temporary Disability/ Temporary Partial Disability and how long? ____________

Did the doctor/health care provider care help you? Yes No Some Please Explain: ____________
Did the doctor/health care provider referred to anyone else? Yes No If yes, please list: ____________

Feel free to note any other important information about the doctor/ health care provider: ____________

4th Doctor's name ____________
What is the health care provider specialty: Doctor of Chiropractic/Chiropractic Physician/Neurologist /Orthopedist/Family Practitioner/General Practitioner/Physical Therapist/Licensed Massage Therapist/Other:

When was your 1st visit (date)?
Who referred you to this health care provider? ____________
What test did this doctor/health care provider perform or order? ☐EMG ☐NCV ☐EKG

☐X-rays Head/Neck/Back/Chest//Ribs/Right Left Shoulder/Right Left Arm/Right Left Wrist/ Right Left Hand/Right Left Leg/Right Left Hip/Right Left Knee/Right Left Ankle/Right Left Foot
☐Scan MR/MRI/CT(CAT) Head/Brain/Neck/Back/Other: ____________
☐Nuclear/Bone Scan

What did the doctor tell you was wrong/diagnosis? ____________
What treatment did the health care provider give to you? Adjustments/Physical Therapy/Home Rehabilitation Stretches Exercises/Medicines (Please list)/Surgery/Operation (Please List) ____________

Are you currently seeing this health care provider? Yes No If yes, how often? ____________
Did the doctor/health care provider place you on any work restrictions? Yes No If yes, what type of restrictions Total Temporary Disability/ Temporary Partial Disability and how long? ____________

Did the doctor/health care provider care help you? Yes No Some Please Explain: ____________
Did the doctor/health care provider referred to anyone else? Yes No If yes, please list: ____________

Feel free to note any other important information about the doctor/ health care provider: ____________

If you have seen more doctors please tell the staff and they will provide you with another form.

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Name: ____ Date:

Did the insurance company require you to see their doctor? Yes No If yes,
What was the date of examination? ____
What was the doctor's name? ____
Do you have the letter/report from that doctor? Yes No If yes, have you reviewed it? Yes No ☐ Please fill out the Patients Report Of Insurance/Defense Medical/Chiropractic Examination Form! Please provide this facility with the report. ☐

Have you had previous injuries (before the incident in question) or collisions where you were hurt? Yes No
Description of previous incidents:
1. ____
____
2. ____
____
3. ____
____

Description of previous injuries:
1. ____
____
2. ____
____
3. ____
____

What pains did you have in the weeks to months before this collision?:
1. ____
____
2. ____
____
3. ____
____

Do you smoke? Yes No If yes, What do you smoke? Cigarettes/Cigars/Marijuana/Clove Cigarettes
How many years have you smoked? _____ Years
How many packs or cigarettes per day?____ Packs/Cigarettes per day
Do you drink Alcohol? Yes No If yes, what do you usually drink? Beer/Wine/Hard Liqueur
Do you drink Daily/Weekly/Monthly/Yearly?

Who was your Employer at the time of the crash? ______________________________
What was your job description? ______________________________
Were you working full/part time? How many hours per week were you working? ______________
At the time of the collision were you in school? Yes No If yes, what school? ______________
What class/grade? ______________________________
Who is your Current Employer? Same ______________________________
What was your current job description? Same ______________________________
Are you currently working full/part time? ______________________________
How many hours per week are you working? ______________________________

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Name: ________________________________ Date:

Has any doctor/physician placed you on disability since your injury? Yes No Total Temporary Disability/Total Partial Disability (light duty) Doctors Name:________________________________

Are you currently on Total Temporary Disability/Total Partial Disability (light duty)? If yes, Why? I have current work restrictions or difficulty with None • Lifting ___________ (lbs) • Stooping • Bending • Squatting • Kneeling • Sitting • Standing

Have you lost time from work Yes No If yes, please list total days/weeks or months of work loss:

____

____

Is there any difference in your job description, physical area or your abilities since the loss?

____

____

If you were not working at the time of the crash please state why? • Unemployed • Retired • Disabled • Other:

____

Currently do you have problems or difficulty with any activities of daily living Talking/Communicating /Washing /Bathing/Washing Hair/Brushing Combing Hair/Hearing/Seeing/Feeling (touching)/Tasting/Smelling /Grasping /Sexual Function/Sleeping. Comment(s):________________________________

____

____

____

Do you have problems or difficulty with any of the following activities? If yes, please list how long you can perform the activity before symptoms increase or you have to change positions: (M = Minutes, H = Hours)

Activity	Walking	Sitting	Standing	Stairs
Time Limit				
Activity	Driving in a vehicle	Riding in a vehicle	Flying in an airplane	Other:
Time Limit				

Do you live in an apartment or town home? Yes No If no, previous to the crash did you have household responsibilities? Yes No. Previous to the crash did you have yard responsibilities? Yes No If yes, please circle any activities you are currently having difficulty and list limitations you have with these activities.

Activity	Vacuuming	Sweeping	Mopping	Lifting
Limits				
Activity	Picking up	Dishes	Cooking	Laundry
Limits				
Activity	Mowing Lawn	Rake	Digging	Snow Shoveling
Limits				

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Name: ______________________________ Date:

What hobbies or other enjoyable activities did you do before the collision that you no longer do or do with difficulty?

Past Medical Conditions: Please list dates (or how old you were and if you had any ongoing problems since this condition(s)):

What surgeries/operations have you had? None

Appendectomy Year

Hysterectomy Year

Tonsillectomy Year

C-sections: # 1 2 3 4 Year(s)

Have you had and broken bones or fractures? Yes No If yes, please list why and if you had and associated surgeries or ongoing problems:

What serious illnesses have you had? None High Blood Pressure/Diabetes Type I II III/Hypothyroidism/Other:

Have you ever tested positive for HIV? Yes No

What are you allergic to? Nothing Penicillin/Sulfa/Codeine/Animals/Hay fever/Dust/Pollen/Grass

What current medication or drugs are you taking? None Aspirin/Ibuprofen/Tylenol/Birth Control Pills /Prozac/Zoloft/ Muscle Relaxers If you already have a list the staff will make a copy for you. (Circle the number of pills you take per day and the dose/milligrams?) Please place an * next to the name of the medications you have taken today?

______________________ 1 2 3 4 5 6 7 8/D ___ mg

______________________ 1 2 3 4 5 6 7 8/D ___ mg

______________________ 1 2 3 4 5 6 7 8/D ___ mg

What other car crashes, collisions, injuries, work related or other traumas or injuries have you had **since** this incident? None

Have you ever been injured on the job that required seeing a doctor? Yes No If yes, please list injuries, dates, impairments, settlements/awards etc.:

1.

2.

3.

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Name: ______________________________ Date:

Have you ever been injured in another car crash that required seeing a doctor? Yes No If yes, please list injuries, dates, impairments, settlements/awards etc.:

1.

2.

3.

Have you ever been injured as a pedestrian, in a slip and fall, skiing, boating, biking motorcycle, snowmobile, 4 wheeling, horseback riding etc. that required seeing a doctor? Yes No If yes, please list injuries, dates, impairments, settlements/awards etc.:

1.

2.

3.

Have you ever been injured in sports, military, domestic (at home), or other head, neck back injuries that required seeing a doctor? Yes No If yes, please list injuries, dates, impairments, settlements/awards etc.:

1.

2.

3.

Have you ever seen a chiropractic doctor/physician before this incident? Yes No If yes, please list the doctors and reason for the visit(s).

1.

2.

3.

Do you currently use a neck/cervical collar? Yes No If yes, how often do you use a neck collar?

Do you currently use a neck/cervical pillow prescribed by a doctor? Yes No If yes, how often do you use a neck pillow?

Do you currently use a neck/cervical stretch or traction device? Yes No If yes, how often do you use it?

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Name: ______________________________ Date:

Do you perform home rehabilitation/stretching/exercises? If yes, who prescribed them for you?

____

How often do you do these? Daily/Several times a day/Weekly/ When I hurt/When I feel I need to:

____

I certify that to the best of my understanding and knowledge that all the above are true.

Patient Signature:______________________________

Date:______________________________

Please hand this information to the staff when you are done.

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