PERSONAL INJURY INTRODUCTION FORM

PATIENT INFORMATION

Today's Date: _____

Last Name: **MI:** **First Name:**	
Home Address: **City:** **State:** **Zip:**	
Date Birth: Age:	Social Security No:
Height: Weight:	Drivers License No:
Employer's Name:	Marital Status (Circle): Single, Married, Divorced, Widowed
Occupation:	Name of Family Physician:

☐ **YES,** ☐ **NO I authorize the following telephone numbers:** ☐ **YES,** ☐ **NO I authorize the use of my name/address** Home: _____Work _____ Cell: _____ Pager: _____ Indicate if you have a preferred mailing address: _____ _____ Signature: _____Date:_____ Expiration Date/Event for Authorization: ☐ No expiration date ☐When I have discontinued treatment and all bills have been paid. ☐ Date:	Dr Dhesi, 1081 Market Place, Suite 100, San Ramon, CA 94583, needs to leave messages, return telephone calls, and send office mail to your home address as part of our normal practice. Federal/State HIPAA patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. Please list telephone numbers that are acceptable for our office to call. Your agreement will allow our office to use your name and the indicated mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements/questions, status of your account, and other office related matters. We will use your home address, noted above, unless you indicate a preferred address. You may indicate a preferred mailing address by indicating so on this form. This authorization may be revoked by you at any time, by advising our office (Privacy Officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

AUTOMOBILE INSURANCE INFORMATION

Do you or someone else have insurance coverage for the vehicle you were in?	☐ I have, ☐ Someone else has coverage. Indicate the name of the person that the policy is under:
How is this person related to you?	☐ Self, ☐ Parent, ☐ Friend, ☐ Other
Name of your Automobile Insurance Carrier:	
Address of your Automobile Insurance Carrier:	
Claim Adjusters Name/Telephone Number:	Name: Telephone (area code):
Claim Number:	
Do you have an Insurance Deductible?	☐ Yes, ☐ No Deductible is: $
Do you know your Policy Limits for medical bills?	☐ Yes, ☐ No Limit is: $
Have you reported this injury to your insurance carrier?	☐ Yes, ☐ No

☐ Yes, ☐ No. Do you have an attorney representing you? If yes, indicate name, address and telephone of your retained attorney:	Attorney Name: _____ Address: _____ Telephone:

Our office will provide insurance billing services for you if you so desire as a courtesy. Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier.

Patient Signature Date	I am ultimately responsible for all charges that are incurred at the doctor's office. I agree to pay for any outstanding bills incurred in this office, as well as paying for co-insurance or deductibles.

Doctor's Name/Address: Sarbjit Dhesi, DC, 1081 Market Place, Suite 100, San Ramon, CA 94583

GENERAL HEALTH HISTORY

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
☐	History of poor healing or told that you have a healing disorder?	☐	☐
☐	Smoke cigarettes or use tobacco products?	☐	☐
☐	Diabetes, hypoglycemia, thyroid, kidney, liver disease, or other endocrine disorder?	☐	☐
☐	Heart attack, heart disease or have a heart pacemaker or neck or chest shunt?	☐	☐
☐	History of any disease such as AIDS, Tuberculosis, Meningitis, etc.?	☐	☐
☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	Do you have problems with dizziness, blacking out, balance, fainting, or tripping?	☐	☐
☐	Epilepsy-Seizure-Convulsion history or any other neurological disease?	☐	☐
☐	History of multiple sclerosis, lupus, psoriasis, paralysis, or disease affecting nerves?	☐	☐
☐	Cancer history or cancer treatment of any type?	☐	☐
☐	Stroke history (Indicate any suspected strokes or transient ischemic attacks)?	☐	☐
☐	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae?	☐	☐
☐	Told that you have a bulging/herniated disc or disc degeneration in the spine?	☐	☐
☐	Have you ever been hospitalized? Why/When:	☐	☐
☐	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm?	☐	☐
☐	Hypertension or high blood pressure? If yes, name of MD seeing:	☐	☐
☐	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis?	☐	☐
☐	Told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints?	☐	☐
☐	**Do you have any type of chest or breast implants presently (males & females)?**	N/A	☐
☐	**Women only**: Check box to left if there any chance that you are currently pregnant		

PRIOR INJURY AND/OR PREVIOUS PAIN (☐ I have never had any injuries or pain) If yes, check below:

☐ Work Injury	☐ Fall	☐ Sports Injury	☐ Lifting Injury	☐ Car Accident
☐ Motorcycle Injury	☐ Head Injury	☐ Pedestrian Injury	☐ Military Injury	☐ Other Injury
☐ Headaches	☐ Neck Pain	☐ Middle Back Pain	☐ Low Back Pain	☐ Shoulder Pain
☐ arm numb/tingling	☐ Arm Pain	☐ Leg Pain/Tingling	☐ Other Pain:	

Describe:

FRACTURES/BROKEN BONES HISTORY

(☐ I have never had any broken bones). If you have broken/fractured any bones, indicate where and when below:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone (clavicle)		☐ Rib(s) or sternum chest bone	
☐ Arm or hand bones		☐ Leg or foot bones	
☐ Pelvis or hip bones		☐ Other: List	

PREVIOUS SURGERIES

(☐ I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine Surgery (neck, back, or pelvis)		☐ Abdominal/chest Surgery or Appendix	
☐ Disc surgery in neck or back		☐ Gallbladder/Liver/Stomach/Kidney	
☐ Heart		☐ Cancer (any type)	
☐ Head/Brain/Spinal Cord/Nerve		☐ Hernia (inguinal or hiatal)	
☐ Shoulder/Arm/Hip/Leg		☐ Other	

When did you have your last physical examination by a medical doctor? Year: _____ Name MD: _____

Doctor's Name/Address: Sarbjit Dhesi, DC, 1081 Market Place, Suite 100, San Ramon, CA 94583

GENERAL HEALTH HISTORY (Page 2)

☐ No, ☐ Yes **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, spinal cord, brain, nerves, or other diseases? If yes, please describe:____
_____

☐ No, ☐ Yes **Have you ever been to a Chiropractor before for any condition?**
If yes, Chiropractor's Name/City : _____ Year:_____
List Problem(s) that the Chiropractor treated you for:_____

☐ No, ☐ Yes **Do you have any problems laying face down on an examination table**, including tender chest/breast, level of pain, etc? If yes, why: _____

ARE YOU TAKING ANY MEDICATIONS PRESENTLY?

☐ **I am not taking any medications currently.** Check any of the following that you are taking currently.

☐ Muscle Relaxants	☐ Blood pressure/Stroke prevention medications	☐ Cortisone injections
☐ Pain/Anti-inflammatory meds	☐ Osteoporosis (bone strengthening) medications	☐ Other:

WHEN IS YOUR PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN?

☐ Morning is when pain is worse	☐ Bending your back increases pain	☐ Walking increases pain
☐ Afternoon/evening pain worse	☐ Lying down flat increases pain	☐ Standing increases pain
☐ During sleep hours pain worse	☐ Sitting increases pain	☐ Exercise/Stretching increases pain
☐ Standing up from sitting	☐ Poor posture increases pain	☐ Other:

WHAT ACTIVITIES LESSEN YOUR PAIN?

☐ Walking	☐ Being flat on your back	☐ Exercise/Stretching
☐ Sitting	☐ Standing	☐ Other:

DO YOU EXERCISE?

☐ I do no regular exercise	☐ I exercise 1-2 times a week	☐ I exercise 3-5 times a week
☐ I stretch regularly	☐ I do weight lifting at gym/home	☐ I do cardiovascular work outs
☐ I am willing to do exercise	☐ I am not willing to do exercises	☐ I do regular sports activities

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

☐ Excessive fatigue-malaise	☐ Bowel or bladder disorders	☐ Night pain or night time sweats
☐ Weight loss	☐ Ovarian pain	☐ Abdominal pain
☐ Low grade fever	☐ Kidney pain/painful urination	☐ Balance problems

Since the injury did your pain and other symptoms come on? ☐ Suddenly, ☐ Gradually

Doctor's Name/Address: Sarbjit Dhesi, DC, 1081 Market Place, Suite 100, San Ramon, CA 94583

SYMPTOM QUESTIONNAIRE (Page 3)

Please answer the following sections that apply to you. If some of the questions are unclear to you, skip ahead to the next question. Your doctor will be going over this questionnaire with you during your consultation, and you can clarify your answers at that time.

NECK REGION

YES	NO	
☐	☐	Does neck and head movement cause your neck pain to intensify?
☐	☐	Do you get dizzy when you look up or twist your head? If yes, how often:
☐	☐	Do you black out or lose your balance when you look up or twist your head? If yes, how often:
☐	☐	Do you have to support your head with your hand or grasp your mouth or hair to be able to lift your head up when you are lying down and attempting to sit up? If your difficulty/inability to lift your head without support is injury related, indicate how soon this occurred after injury? (_____min/hrs)
☐	☐	Do you feel your neck pain sends pain downwards between your shoulders?
☐	☐	Do you feel your neck pain sending pain downwards to the front of your chest?
☐	☐	Have you noticed your head leaning or tilting to one side recently?
☐	☐	Have you ever been diagnosed as having a disc bulge or disc herniation in your neck?

ARM, HAND, OR FINGER REGION

YES	NO	
☐	☐	Do you have pain, numbness, or tingling in your shoulder, elbow, forearm, or hand? Circle areas
☐	☐	Do you have pain, numbness, or tingling in your fingers? If Yes, circle finger(s) that are involved: Thumb, Index finger, Middle finger, Ring finger, Little finger
☐	☐	Do you get increased arm numbness when lying flat on your back or sleeping on your side?
☐	☐	Does changing your sitting posture increase your arm/hand symptom intensity?
☐	☐	If you sit and slouch forward for several minutes, do your arm symptoms intensify?
☐	☐	If you have arm symptoms, do they improve when you lift your arms over your head?
☐	☐	If you have arm symptoms, do they worsen when you lift your arms over your head?
☐	☐	If you have hand or arm pain at night, does it help to shake and massage them?
☐	☐	Do your hands feel tender when you grasp objects?
☐	☐	Do you feel weakness in your grip strength?
☐	☐	Do you drop objects from your hand?
☐	☐	Do you have difficulty writing or doing small motions with your fingers recently?
☐	☐	Do your hand(s) or wrist swell?
☐	☐	Do your hands burn?
☐	☐	Are your fingers or hands frequently cold?
☐	☐	Have you been diagnosed as having Carpal Tunnel Syndrome or Raynaud's syndrome in your past?

MIDDLE BACK AND CHEST WALL REGION

YES	NO	
☐	☐	Do you have pain that shoots or radiates outward along your rib cage?
☐	☐	Does your middle back or chest wall pain intensify when you take in a deep breath or cough?
☐	☐	Does your middle back or chest wall pain intensify when you twist your torso, bend, or stoop forward?
☐	☐	When you move your neck around, does your middle back pain or chest pain increase?
☐	☐	Have you been diagnosed as having angina before?
☐	☐	Do you have a tight band-like feeling sometimes around your chest?
☐	☐	Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
☐	☐	Does your middle back pain mostly bother you during sleep?

SYMPTOM QUESTIONNAIRE (Page 4)

LOW BACK, HIP AND LEG/FOOT REGION

Check any of the following that intensify your low back pain and/or leg symptoms:

☐	Sitting	☐	Bending forward	☐	Standing up	☐	Walking
☐	Standing still	☐	Bending backward	☐	Lying on your back	☐	Putting on shoes

Check any of the following that lessen/improve your low back pain and/or leg symptoms:

☐	Sitting	☐	Bending forwards	☐	Standing up	☐	Walking
☐	Standing still	☐	Bending backwards	☐	Lying on your back	☐	Putting on shoes

Check all locations of any current leg pain, numbness, or tingling:

☐	Hip	☐	Buttock	☐	Back of thigh	☐	Calf
☐	Groin area	☐	Knee	☐	Front of thigh	☐	Foot/toes

YES	NO	***Check all areas with a yes or no (Skip if you are unclear about question)***
☐	☐	When you cough, sneeze, or bear down to have a bowel movement, does your back/leg pain get worse?
☐	☐	Do you have a consistent pattern of getting severe leg pain or cramping after walking for similar distances that is relieved by resting or sitting down? This pain resumes after walking for same distance.
☐	☐	Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down? This pain doesn't bother you at night or while sitting.
☐	☐	Does either leg or foot drag on the floor when you walk?
☐	☐	Do you have a lot of leg cramps at night recently?
☐	☐	Have you recently had any urinary or bowel incontinence or had difficulty urinating?
☐	☐	Have you had abdominal pain, indigestion, colicky symptoms with your low back pain?
☐	☐	Have you observed that your low back pain is not relieved or made worse by any type of postural change?
☐	☐	Do your feet feel cold recently? If yes, indicate which foot or if both feet:
☐	☐	Have you ever been diagnosed as having a herniated or bulging disc in your low back in the past?
☐	☐	Have you ever had an injection of Chymopapain into your discs (Spine) in your back or neck?
☐	☐	Have you recently noticed that either of your legs occasionally gives out on you when you walk?
☐	☐	Does one or both of your legs feel weak recently?
☐	☐	Have you ever been diagnosed as having a spondylolisthesis in your low back region?
☐	☐	Have you or either of your parents ever been diagnosed as having an abdominal aneurysm?
☐	☐	If you have radiating leg or foot pain did you notice your leg symptoms before the low back pain started?
☐	☐	If you have leg pain, is your pain primarily focused in front of your thigh(s)?
☐	☐	Has your anal-rectal region been completely numb?
☐	☐	Do you have any recent prostate, ovarian, or uterine problems?
☐	☐	Have you ever had abdominal surgery, chest surgery, reconstructive surgery or other conditions in your past where your doctor has recommended that you should be careful when twisting or lifting?
☐	☐	Other:

SLEEPING PATTERNS

YES	NO	
☐	☐	Do you sleep poorly at night?
☐	☐	Do you sleep on your stomach?
☐	☐	Do you consistently feel extremely tired when you wake up in the morning?

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

Patient Name: _____ Date: _____

PATIENT INSTRUCTIONS: *It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom listed below does not apply to you.*

SYMPTOM LIST **(Check all that apply to you)**	**BEGAN IN LESS THAN 24 HOURS AFTER INJURY**	**BEGAN 1 TO 7 DAYS AFTER INJURY**	**YOU HAVE SYMPTOMS PRESENTLY**	**HAD SIMILAR SYMPTOMS WITHIN 12-MONTHS PRIOR TO THE INJURY**
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Nausea or vomiting				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Loss of smell				
Pain/difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching/stiff				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Chest pain or bruising				
Rib cage pain or bruising				
Abdominal-Pelvic pain or bruising				
Low back pain/soreness/aching				
Hip pain or bruising				
Upper leg or thigh pain				
Leg numbness/tingling				
Pain radiating down leg(s)				
Lower leg or calf pain				
Knee pain				
Ankle/foot/toe pain				
Other				

Doctor's Name/Address: Sarbjit Dhesi, DC, 1081 Market Place, Suite 100, San Ramon, CA 94583

MOTOR VEHICLE CRASH FORM (Page 1)

Patient Name:_____ Date: _____
Date of crash:_____ Time of collision: _____ ☐ AM ☐ PM
City where crash occurred: _____ Was the street wet or dry? ☐ Wet ☐ Dry
Street (location) where crash occurred: _____
Who owns the vehicle in which you were hit? _____
What is the estimated repair damage to your vehicle? $_____ ☐ Unknown, ☐ Estimate not done yet
How many people were in your vehicle at the time of the crash? _____
☐ Yes, ☐ No Did the police come to the crash scene?
☐ Yes, ☐ No Did the police make a written report?
☐ Yes, ☐ No Were any photographs taken of the vehicles? If yes, who took them?

DESCRIBE HOW THE CRASH HAPPENED

_____
_____
_____
_____

COLLISION DESCRIPTION-TYPE

Check all that apply to you. Indicate which type of automobile crash you were involved in:

☐	Single-vehicle crash	☐	Two-vehicle crash	☐	Three-or-more vehicles
☐	Rear-end crash	☐	Side crash	☐	Rollover
☐	Head-on or frontal crash	☐	Hit guard rail, tree, or object	☐	Ran off the road
☐	Other (Describe):				

CIRCLE YOUR SEATING POSITION **(The number's 1-9 indicate where you were seated at the time of the crash. The #1 spot is the driver. Seating numbers 7-9 are for a third row seat.**

Front of Vehicle

1 2 3

4 5 6

7 8 9

Rear of Vehicle

DESCRIBE THE VEHICLE YOU WERE IN (If not certain, check unknown):

Model, Make, and Year: ☐ Unknown

DESCRIBE THE OTHER VEHICLE (If not certain, check unknown):

Model, Make, and Year: ☐ Unknown

Doctor's Name/Address: Sarbjit Dhesi, DC, 1081 Market Place, Suite 100, San Ramon, CA 94583

MOTOR VEHICLE CRASH FORM (Page 2)

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

☐	Slowing down	☐	Gaining Speed	☐	Unknown speed
☐	Stopped	☐	Moving at steady speed	☐	Other:

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

☐	Slowing down	☐	Gaining Speed	☐	Unknown speed
☐	Stopped	☐	Moving at steady speed	☐	Other:

DURING AND AFTER THE CRASH, YOUR VEHICLE:

☐	Kept going straight, not hitting anything	☐	Spun around, not hitting anything
☐	Kept going straight, hitting car in front	☐	Spun around, hitting another car
☐	Was hit by another vehicle	☐	Spun around, hitting object/curb other than car

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING:
Please draw lines from the body regions on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side of door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Direct contact with other vehicle (hood)
Hip/abdomen	Frame/Pillar within vehicle near window
Knee	Roof or top part of vehicle
Leg	Another person sitting in your vehicle
Foot	Other

CHECK IF ANY OF THE FOLLOWING PARTS OF YOUR VEHICLE WERE DAMAGED IN THE COLLISION:

☐	Windshield	☐	Seat bent or damaged	☐	Dash or area around knee/foot
☐	Steering wheel	☐	Side or rear window broken	☐	Other
Describe Damage:					

ALL TYPES OF COLLISIONS Indicate those relevant to your case.

YES	NO	
☐	☐	Did any of the interior front or side structures within your vehicle, such as the side door, dashboard, steering wheel, or floorboard of your car dent inward during the crash?
☐	☐	Did the side door, dash, or interior of your vehicle touch or hit your body during the crash?
☐	☐	Did you strike or did any objects or animals within your vehicle hit you during the crash?
☐	☐	Was the door(s) of your vehicle damaged to a point where you could not open the door?
☐	☐	Did an airbag deploy in your vehicle during the crash? If yes, circle (side airbag/front airbag)
☐	☐	Did you have any cuts, bruises, or abrasions from the airbag deploying?
☐	☐	Did your seatbelt system require repairs after the crash?
☐	☐	Was the back of your seat that your were sitting in damaged or bent during the crash?
☐	☐	If a side impact, did the front of the other vehicle strike the door next to where you were sitting?

Patient Name:	Doctor's Name: Sarbjit Dhesi, D.C.

MOTOR VEHICLE CRASH FORM (Page 3)

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

YES	NO	
☐	☐	Were you wearing a seatbelt? If yes, does your seatbelt have a: ☐ Lap and Shoulder Strap, ☐ Automatic shoulder strap with driver needing to manually attach lap belt, ☐ Lap belt only
☐	☐	Did you have any portion of your seatbelt positioned behind your chest, back or shoulder.
☐	☐	Did you have any cuts, bruises, or abrasions from the seatbelts?
☐	☐	Were you holding onto the steering wheel (driver only) at the time of impact? If yes, Indicate where each hand was positioned ***(Use time clock face as your reference point)*** Left hand: ☐ Not on wheel, ☐ Yes, hand at ____ o'clock, ☐ Hand elsewhere Right hand: ☐ Not on wheel, ☐ Yes, hand at ____ o'clock, ☐ Hand elsewhere

REAR-END COLLISIONS ONLY Answer this section only if you were hit from the rear.

Describe your vehicle's head restraint system:

☐ Movable/adjustable head restraint ☐ Fixed, non-moveable head restraint
☐ No headrests in my vehicle ☐ Bench seat in your vehicle without head restraint

Please indicate how your <u>head restraint</u> was positioned at the time of crash (if present):

☐ At the top of the back of your head ☐ Midway height of the back of your head
☐ Lower height of the back of your head ☐ Located at the level of your neck
☐ Level of your shoulder blades

BRUISING AFTER THE CRASH?

YES	NO	
☐	☐	Did your body have any bruising (areas that were visibly black, red, and/or blue) after the crash? If yes, indicate where bruising was located on your body and what caused the bruising (if known):

AWARENESS AND BODY POSITION DESCRIPTIONS: *Check all areas that apply to you.*

☐	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
☐	You were aware of the impending crash and relaxed before the collision.
☐	You were aware of the impending crash and braced yourself.
☐	Your body, torso, and head were facing straight ahead.
☐	You had your head and/or torso turned at the time of collision: ☐ Turned to left, ☐ Turned to right Describe how far you were turned/twisted and why you were turned/what were you doing?
☐	You were leaning forward at the time of impact resulting in a gap between your body and the seatback. If yes, indicate how far you were leaning and why you were leaning forward?
☐	Your torso/body were positioned normally against the seatback with no gaps due to leaning/twisting.

HOW SOON DID YOU *FIRST* NOTICE ANY PAIN/SORENESS AFTER THE CRASH?

_____