Summit Chiropractic
Dr. Kent G. Carlomagno
710 C.Street., # 12
San Rafael, Ca 94901
(415) 721-7520

NAME_____

DATE_____

PI QUESTIONNAIRE

Please answer the following questions as accurately and honestly as possible while the information is fresh in your mind. This form is very important and will aid your doctor in providing you the best care as well as providing your attorney with a complete and accuate medico-legal narrative report if one is needed. If unable to answer a question please circle the number of the question in the left hand margin. YOU MUST MARK EVERY QUESTION.

MEDICAL HISTORY

1. Are you married_____single____separated____divorced____?
2. How many children do you have? _____
3. Do they live with you? Yes___ No ___
4. Do you live alone? Yes ___ No ___
5. Do you have roommates? Yes ___ No ___
6. Do you smoke? Yes ___ No ___
7. If "yes," what and how much?_____
8. Have you ever served in the military? Yes ___ No ___
9. If "yes", during what time frame?_____

ACCIDENT/INJURY INFORMATION

1. Were your wearing seatbelts? Yes___ No ___
2. Were you wearing a shoulder harness? Yes ___ No ___
3. Did you receive any fractures (broken bones), cuts, bruises (black and blue marks, or abrasions (skinned elbows, knees)? Yes ___ No ___
4. If "yes", please describe_____

_____

5. How many people were in your vehicle?_____
6. Describe their relationship to you (friend, co-workers,

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brother,etc.)_____

7. Please describe briefly their injuries as you know them._____

_____

_____

8. How many people were in the vehicle that struck you or that you struck?_____

9. Were any of them injured? Yes ___ No ___

10. Were there any fatalities? Yes ___ No ___

11. Were the police called to the scene? Yes ___ No ___

12. Did they file a report? Yes ___ No ___

13. Did you get the license numbers of the other vehicle involved? Yes ___ No ___

14. Did you get insurance information from drivers of the other vehicles involved? Yes ___ No ___

15. Was this a hit-and-run? Yes ___ No ___

16. Please describe your vehicle: Year _____ Make _____ Model _____

17. Please describe other vehicles (s):

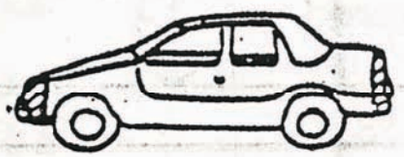
Vehicle #2 Year _____ Make _____ Model _____

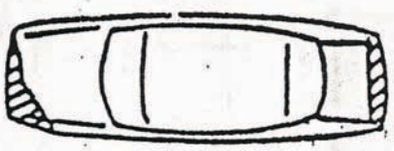
Vehicle #3 Year _____ Make _____ Model _____

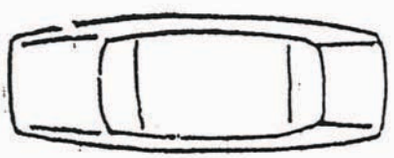
Vehicle #4 Year _____ Make _____ Model _____

18. Please draw a diagram of the amount of damage to your vehicle.

Examples:







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AFTER THE ACCIDENT:

1. How did you leave the accident scene? In my car _____

   by ambulance _____, other (cab, friend, etc.)_____

2. Were you taken to a hospital? Yes ___ No ___

3. If "yes", which one? _____

4. How many doctors attended you there?_____

5. Do you remember their names?_____

_____

6. Were X-Rays taken there? Yes ___ No ___

7. If "yes", what areas were X-Rayed?_____

_____

8. Did you receive any medications, stitches, bandages, shots, braces, collars, etc.,? Please describe_____

9. Was any surgery performed? Yes ___ No ___. If "yes", please describe_____

_____

10. How long were you in the hospital?_____

11. What was the diagnosis?_____

12. Were you told to see any other doctors?_____

13. Were any recommendations made for rest, ice, heat,chiropractic, physical therapy or time off of work? Yes ___ No ___

14. If "yes", please describe_____

_____

15. Please describe how you felt immediately after the accident (angry, upset, shocked, stunned, OK, neck pain, back pain, etc.)_____

_____

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16. Please describe how you felt the next day_____

_____

17. Please describe any of your normal activities which you could not perform as a result of the accident (work, sleep, jogging, etc.)_____

18. Have you lost any time from work a result of the accident? Yes ___ No ___

19. If "yes", how much? Total days_____ Partial days _____

20. Please describe your problems which resulted from the accident as they are TODAY (Do not describe areas that have now healed or recovered)._____

_____

21. Please describe normal activities which you cannot perform

_____

_____