

Personal injury / Workers' Compensation Questionnaire

Name: _____ Date of accident: _____ Time: _____

Where did accident happen? _____

Describe the accident in your own words:

What was your position in the car? Driver Passenger

If passenger, where were you sitting? Front Right Rear Left Rear

Did your vehicle strike other vehicle? Yes No

Was the impact from: the front the right side the left side the rear

At the time of impact were you: looking straight ahead looking right looking left

Were both hands on the steering wheel? Yes No

Was your foot on the brake? Yes No

Were you braced for impact? Yes No

Where in the car were you after the accident? _____

Were you wearing seat belts? Yes No

Did you strike anything in vehicle at time of impact? Yes No

If yes, please specify: Steering wheel Dashboard Windshield Side Door Arm Rests

Please state part of body: Chest Chin Knee Shoulder Hand Head

Immediately following the accident how did you feel?

Were you unconscious? Yes No In a daze? Yes No

Did you go to the hospital? Yes No

If you went to hospital when?

At time of accident? Yes No Next day? Yes No

How did you get to hospital?

Ambulance Yes No Private Transportation Yes No

Did the ambulance attendants place you in:

Neck Collar: Yes No Splints: Yes No Brace: Yes No

Name of hospital: _____

Attended by Dr: _____

Were x-rays taken: Yes No What was the diagnosis: _____

Were you admitted to the hospital: Yes No How long did you stay: _____

What treatment was rendered? _____

What recommendations were made?

See own doctor See orthopedist Physical therapy Other: _____

Have you seen any other doctor as a result of this accident? Yes No Name: _____

Is your pain constant? Yes No Is the pain off and on? Yes No

Is your pain Sharp? Yes No Dull? Yes No Other: _____

Is your pain worse by:

Rising from a chair? Yes No Straining? Yes No Sneezing Yes No Coughing? Yes No

Do you have any numbness or tingling in your arms? Yes No In hands? Yes No

Personal injury / Workers' Compensation Questionnaire

In fingers? Yes No In legs? Yes No In feet? Yes No In toes? Yes No

What is your most comfortable position?

- Sitting Lying on right side Lying on left side
 Lying on your back On your stomach Standing

Is it difficult for you to move around in bed? Yes No

Does stretching and twisting worsen the pain? Yes No

Do any of the following relieve your pain?

- Heating Pad Hot Bath Shower Ice Pack

Does a brace (if you have tried one) relieve the pain? Yes No

Does a change in hell height worsen the pain? Yes No

Do you feel better moving around? Yes No Do you feel better resting? Yes No

Do you have a firm mattress? Yes No

Do your knees ache or hurt? Yes No

Do you have cramps in your legs? Yes No Do you have cramps in your arms? Yes No

Have you had any change in your bowel habits? Yes No

Have you lost any time from work because of this accident? Yes No

If yes, give dates of time lost: From _____ to _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

BEFORE your Accident, estimate your total lifting effort ability:

- 1. How much weight? Maximum Average
2. How far could you carry this weight? _____ for how long a period of time? _____
3. Was this lifting done at work? Yes No At home/elsewhere? Yes No
4. How often did you carry this amount of weight? _____

AFTER your ACCIDENT, describe your total lifting ability:

- 1. How much weight can you lift now without experiencing pain, discomfort, or restriction of motion? _____
2. Did you experience this pain, discomfort, or restriction of motion before the accident? Yes No
3. How far can you carry this weight now? _____
4. How long a period of time can you carry this weight? _____
5. How often can you carry this weight? _____
6. Are you now limited in your lifting ability in some body position that you were previously not?
 Yes No If so, specify: _____
7. What symptoms does lifting produce? _____
8. How long do these symptoms last? _____

Are you presently able to:

- LIFT Very Heavy _____lbs Heavy _____lbs Light _____lbs
WORK Very Heavy _____lbs Heavy _____lbs Light _____lbs

What positions can you work in with a MINIMUM DEMAND of physical effort?

With MINIMUM DEMAND of physical effort, what positions can you work in PART TIME and for how long?

- Standing Walking Sitting

Do you feel that you cannot perform any physical work activity? Yes No

Personal injury / Workers' Compensation Questionnaire

Do you feel that you cannot perform any mental work? Yes No

Relate your BEFORE injury capacity (mark B) and your AFTER injury capacity (mark A) for performing the following activities:

- | | | | | |
|--------------|--------------|---------------|-----------------|------------|
| 1. Walking | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 2. Standing | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 3. Sitting | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 4. Bending | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 5. Stooping | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 6. Lifting | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 7. Pushing | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 8. Pulling | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 9. Climbing | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 10. Reaching | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 11. Gripping | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 12. Kneeling | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 13. Balance | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 14. Fatigue | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |

Generally speaking is your inability to perform these functions due to:

- Pain Weakness Structural limitations Nerves

Do you have normal sexual function? Yes No

Are you able to take care of your personal self, such as dressing, bathing etc? Yes No

Do you feel your present condition is temporary? Yes No or Permanent? Yes No

Patient's Signature _____ Date: _____