

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 car? Driver Passenger If passenger, were you sitting in Front Right Rear Left Rear

Did your vehicle strike other vehicle? Yes No Was your car struck by other vehicle? Yes No

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

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

Were both hands on steering wheel? Yes No Was your foot on 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, specify: Steering Wheel Dashboard Windshield Side Door Arm Rests Side Window

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 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 you x-rayed at hospital? Yes No

If so, 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? Yes No See orthopedic doctor? Yes No

Physical Therapy Yes No

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

Doctor's name _____

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

Other _____

Is your pain worse when arising from a chair? Yes No Is it made worse by straining? Yes No By coughing? Yes No

By sneezing? Yes No By straining when moving your bowels? Yes No

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

In your legs? Yes No In your feet? Yes No In your toes? Yes No

What is your most comfortable position? Sitting Yes No Lying on your right side Yes No Lying on your left side Yes No

Lying on your back Yes No On your stomach Yes No Standing Yes No

Other _____ 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) help relieve the pain? Yes No

Does a change in heel height worsen the pain? Yes No Do you feel better moving around? Yes No Or 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 leg? Yes No

In arm? 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:

- How much weight? Maximum Average
- How far could you carry this weight? _____ For how long a period of time? _____
- Was this lifting done at work? Yes No Or at home or elsewhere? Yes No
- How often did you carry this amount of weight? _____

AFTER YOUR ACCIDENT, describe your total lifting ability:

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

Are you presently able to:

- LIFT Very Heavy _____ lbs. Heavy _____ lbs. Light _____ lbs. Sitting _____ lbs.
 WORK Very Heavy _____ lbs. Heavy _____ lbs. Light _____ lbs. Sitting _____ 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

With Minimum Demand of physical effort, can you work in a SITTING POSITION with some degree of walking or standing activity?

- Yes No

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

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 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 Or do you require assistance? Yes No

Do you feel your present condition is temporary? Yes No Or permanent? Yes No

Patient's Signature _____

Date: _____