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:

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 Or at home or 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 now lift without experiencing pain, discomfort, or restriction of motion? ______
2. Did you experience this pain, discomfort or restriction of motion before your accident? ☐ Yes ☐ No
3. How far can you carry this weight now? ______ And for how long a period of time? ______
4. How often can you carry this weight? ______
5. Are you now limited in your lifting ability in some body position that you were previously not? ☐ Yes ☐ No
   If so, specify position ______
6. What symptoms does lifting produce? ______
7. 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:

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

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: ______