PERSONAL INJURY/ WORKERS' COMPENSATION QUESTIONNAIRE

Name: _____ Date of Accident: _____ Time: _____
Where did the accident happen? _____
Describe the accident in your own words: _____
_____
_____
What was your position in car? Driver___ Passenger___ If passenger, were you sitting in: Front___ Rt Rear___ Lt Rear ___
Did your vehicle strike other vehicle? Yes___ No___ Was your car struck by 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 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 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 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 YOU ACCIDENT, estimate your total lifting ability:

1. How much weight? Maximum___ Average ___
2. How far could you carry this weight? _____
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 is 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 with a MINIMUM DEMAND of physical effort? _____

With Minimum Demand of physical effort, what positions can you work 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 yourself, such as dressing, bathing, etc.? Yes___ No___ Do you require assistance? Yes___ No___

Do you feel your present condition is temporary? Yes____ No____ Or permanent? Yes____ No____

Patient's Signature _____ Date: _____