Personal Injury Questionnaire

Today's Date _____ Referred by _____
Name _____
Address _____
_____
Race _____ Marital Status _____ No. of Children _____
Employer _____
Work Address _____
Your Auto Insurance Company _____
Insurance Co.'s Address _____
Your Health Insurance Company _____
Insurance Co.'s Address _____
Attorney's Name _____
Attorney's Address _____ Zip _____
Emergency contact _____

Cell Phone: _____
Social Security # _____
Driver's License # _____
Your Date of Birth _____
Age _____ Sex: ___M ___F
Phone: Home _____
Work _____
Length of Employment _____
Policy # _____
Agent's Name _____
Policy # _____
Ins. Co. Phone # _____
Have you retained an attorney? Yes No
Attorney Phone # _____
Phone No. _____

Information On Other Driver

Other Driver's Name _____
Insurance Co. _____
Address _____ City/State/Zip _____

Third Party Information

Were there any witnesses to your accident? _____Yes _____No
Witness Name(s) _____
_____

Nature of Accident

1. Date of Injury _____ Time _____AM/PM
2. Were you? *(circle one)* Driver Passenger Front Seat Back Seat
3. Number of people in: Your vehicle _____ Other vehicle _____
4. Your vehicle: Make _____ Model _____ Year _____
   Other vehicle: Make _____ Model _____ Year _____
5. Who owns the car? _____
6. Was your car movin g at the time of the accident? _____Yes _____No
7. What direction were you headed? *(Circle one)* North South East West
   on (Name of Street) _____
8. How fast would you estimate you were going? _____mph
9. What direction was the other vehicle headed? North South East West
   on (Name of Street) _____
10. How fast would you estimate the other car was going? _____mph

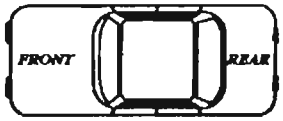
15. Describe the accident

PATIENT NAME: _____ PATIENT ID: _____

Nature of Accident (cont.)

11. Were you struck from the *(circle one)* front rear left right

12. Where was your car struck?



13. Type of Accident: ____Head-on collision ____Broad-side collision
____ Front Impact ____ Rear-end car in front ____ Non-collision

14. Were you: ____ Rendered unconscious ____ In shock
____ Dazed, circumstances vague ____ Other: _____

15. Did you brace for impact? Yes No

16. Head/Body position at the time of impact:
____ Head turned left/right ____ Body straight in sitting position
____ Head looking back ____ Body rotated right/left
____ Head straight forward ____ Other: _____

17. Were you wearing your seat belt? Yes No

18. Were shoulder harnesses worn? Yes No

19. Does your car have head rests? Yes No

20. If yes, what was the position of those headrests compared to your head before the accident? ____ Top of headrest even with **bottom** of head
____ Top of headrest even with **top** of head
____ Top of headrest even with **middle** of neck

21. Were you wearing a hat or glasses? Yes No

22. Road conditions at the time of this accident: wet dry icy rainy _____

23. Visibility at time of accident: ___ poor ___ fair ___ good ___ other: _____

24. Were you aware of the accident prior to the impact? Yes No

25. Were the police notified? Yes No Was an accident report filed? Yes No
What police department? Sheriff CHP City Private (as in parking lots)

26. Where were you taken after the accident? _____

27. Were you able to get out of your vehicle without assistance? Yes No

28. Have you lost time from work as a result of this accident? Yes No
If yes, please complete the following section:
Dates lost _____
Last date worked _____
Type of employment _____

29. Do you notice any activity restrictions as a result of this injury? Yes No
If yes, please describe in detail: _____

30. What is the cost damage to the vehicle you were in? $_____

31. Which of the following car parts broke during this accident?
(circle parts) Windshield Right/Left side window Steering wheel
Front seat (describe which part of the seat) _____
Other (describe) _____

32. Other pertinent information: _____

33. Describe how you felt:

During the accident

Immediately after

Later the same day

The next day

34. On what part of the auto did the following body parts hit?

Head hit _____
Chest hit _____
Rt/Lft shoulder hit _____
Rt/Lft arm hit _____
Rt/Lft leg hit _____
Rt/Lft hip hit _____
Rt/Lft knee hit _____
Other _____

35. Did you get any bleeding cuts?
Yes No If yes, where? _____

36. Did you get any bruises?
Yes No If yes, where? _____

PATIENT NAME: _____ PATIENT ID: _____

37. Circle the symptoms you have noticed ***since*** the accident. Describe the pain. State what aggravates the condition; what relieves the symptom. And finally, indicate with the first letter of the word whether the symptom is ***improving, worse*** or the ***same*** since the accident.

	Describe Pain (sharp, diffuse, burning, stabbing, numb, etc., & does the pain travel?)	Aggrevates Pain (Running, sitting, stretching, twisting, lifting, etc.)	Relieves Symptoms (Heat, ice, medication, stretching, etc.)	*I/W/S (Improving, worse, same)
Headache				
Neck Pain/Stiffness				
Mid Back Pain				
Low Back Pain				
Hip Pain				
L/R Leg Pain				
Cold Feet/Numbness				
Pins & Needles in Arm				
Numbness in Fingers				
Jaw Pain				
Extremity Pain				
Ringing in Ears				
Loss of Balance				
Dizziness				
Chest Pain				
Shortness of Breath				
Depression				
Irritability				
Nervousness				
Tension				
Fainting				
Sleeping Problems				
Fatigue				
Lights Bother Eyes				
Stomach Upset				
Constipation				
Diarrhea				
Loss of Smell				
Cold Sweats				
Fever				
Other				

Please state in the space provided below, any details which you think may be relevant (i.e., lifting aggravates injury; how many pounds lifted; coughing; sitting for how long; whether the pain is worse in the morning or in the evening); and state what normal activity you do at home or at work that aggravates the condition or whether you can perform the activity at all since the accident.

Complaint	Relevant details

EMERGENCY Date _____ Drs. _____

Treatment: X-Rays, Collars, Braces, Medications

Type of Treatment: _____

Recommendations _____

Benefits: _____

PATIENT NAME: _____ PATIENT ID: _____

OTHER DOCTORS SEEN

Dr.'s Name	Specialty	Referred by
1.		
2.		
3.		

Dates	Type of Treatment/X-Ray Results	Results/Recommendations
1.		
2.		
3.		

38. Have you had any new accidents and/or injuries since this accident? Yes No If so, please describe

Past History

Referring to the symptoms listed in question #37, please list any which existed ***prior*** to the accident, describe the pain and indicate whether the symptom has ***improved**, become **worse** or remained the **same** since the accident.

Symptom	Describe Pain	*I/W/S

Do you have any congenital (from birth) factors which relate to this problem?

Yes No If yes, please describe _____

Job Description

State your occupation/job description: _____

How many years have you been doing this type of work? _____ How many hours per week? _____

Physical requirements of your job: (N)=Never 0 (O)=Occasional 25% (I)=Intermittent 50% (F)=Frequent 75% (C)=Constant 100%

Standing	____	Reaching up	____	Reaching	____	Detail work	____	Sitting	____
Walking	____	Kneeling	____	Twisting	____	Lifting	____		
Climbing	____	Stooping	____	Bending	____	Total lbs. in a day			____
Squatting	____	Pushing	____	Driving	____	# of lbs. lifted at one time			____

Past Medical History

Illness/Injury	Date	Work Related	Other (Auto/sports/falls, etc.)

Are you allergic to any food, drug, or pollen? Yes No

If yes, please describe _____

PATIENT NAME: _____ PATIENT ID: _____

Past Medical History

Off work in the past due to _____

Are you pregnant? Yes No Not Sure

Family Health History

	Ill/Well	Deceased	Cause of Death	Age
Mother				
Father				
Sibling				
Sibling				
Sibling				

Name of Family Doctor _____

Address _____

Phone No. _____

Routine/Habits

Average number of hours slept each night: Before injury ____ After injury ____

Do you have: (Please circle if you do) Insomnia Nightmares Restlessness

Do you exercise regularly? Yes No If yes, describe type of exercise: _____

Do you have hobbies? Yes No If yes, please state what it is: _____

Do you use:	How much per day?	per week?
Caffeine		
Alcohol		
Tobacco		
Vitamins/minerals		
Prescription drugs		

Activities of Daily Living Assessment

Directions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section which most closely applies to you.

Section 1 Pain Intensity

- ☐ I can tolerate the pain I have without using pain killers.
- ☐ The pain is bad but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers give no relief from pain and I do not use them.

Section 2 Personal Care (washing, dressing, etc)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

PATIENT NAME: _____ PATIENT ID: _____

Section 4 Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk using a cane or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than one hour.
- ☐ Pain prevents me from sitting for more than 30 minutes.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it causes extra pain.
- ☐ Pain prevents me from standing for more than one hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 Sex Life

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9 Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc.).
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 10 Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours .
- ☐ Pain restricts me to the journeys of less than one hour .
- ☐ Pain restricts me to short necessary trips under ½ hour.
- ☐ Pain restricts me from traveling except to the doctor or hospital.

PATIENT NAME: _____ PATIENT ID: _____

Subjective Pain Level:

On a scale of 1 - 10 place an (X) in your current pain level

NORMAL
☐ 0

LOW PAIN
☐ 1 ☐ 2 ☐ 3

MODERATE PAIN
☐ 4 ☐ 5 ☐ 6

INTENSE PAIN

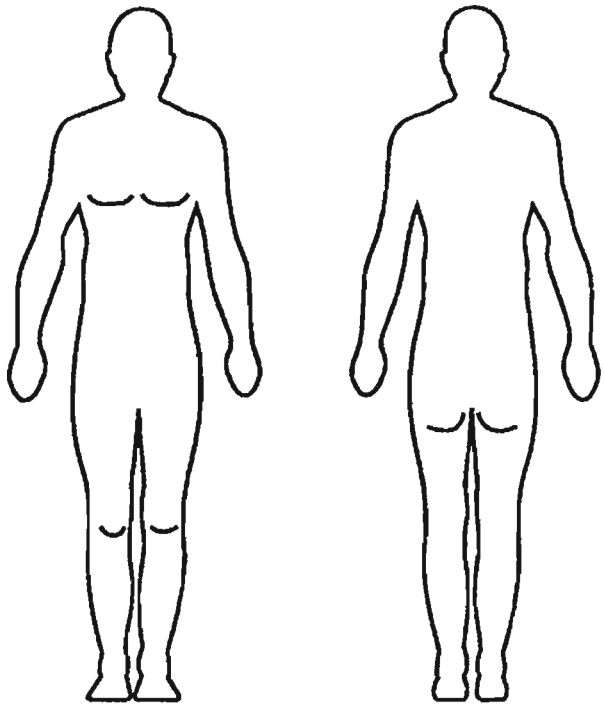
☐ 7 ☐ 8 ☐ 9

EMERGENCY
☐ 10

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.

X NUMBNESS + BURNING

O PINS AND NEEDLES ☐ STABBING



Patient's Signature _____ ***Date*** _____