**PERSONAL INJURY QUESTIONNAIRE**

**NAME ___________________________________________ DATE OF ACCIDENT _________________ TIME ___________**

*Where did the accident happen? ____________________________

*Describe the accident in your own words ___________________________________________

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**PLEASE CIRCLE ANSWERS AND FILL IN WHAT APPLIES TO YOU**

**What was your position in the vehicle?**  
- Driver  
- Passenger  

If passenger, were you sitting in:  
- Front  
- Right  
- Rear  
- Left Rear

**Was your vehicle struck by the other vehicle?**  
- Yes  
- No

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

**How fast was the other vehicle traveling when it hit you? _______________**  
- or  
- Was your vehicle stopped?  
- Yes  
- No

**Were you able to drive your car after the crash?**  
- Yes  
- No

**Did your vehicle strike another vehicle after being hit the first time?**  
- Yes  
- No

**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

- Were you wearing seat belts?  
- Yes  
- No

**Did your Air Bag Deploy?**  
- Yes  
- No

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

- If yes, please specify:  
  - steering wheel  
  - dashboard  
  - windshield side door  
  - arm rests  
  - side window  

- Please state part of body:  
  - chest  
  - chin  
  - knee  
  - shoulder  
  - head

**Describe the setting of your head restraint position:**  
- lowest 1/3  
- highest 1/3  
- middle 1/3

**Did you have immediate pain after the accident?**  
- Yes  
- No

- If yes where  
  - In a daze?  
  - Sharp?  
  - Dull?

**Do you have headaches since your injury?**  
- Yes  
- No

- If yes how frequent? ___________________________

**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

**Is your pain worse when:**  
- Rising from a chair?  
- Yes  
- No

- By coughing?  
- Yes  
- No

- Straining?  
- Yes  
- No

**What is your most comfortable position?**  
- Sitting  
- Lying on your right side  
- Lying on your left side

**Lying on your back**  
- Heating pad  
- Hot baths  
- Shower  
- Ice pack

**On your stomach**  
- Standing  
- Other

**Does this interfere with your normal living and work?**  
- Yes  
- No

- In what way? ____________________________________________________________________________

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**On a scale from 0-10 with 10 being unbearable pain, what is your pain level?**

0 1 2 3 4 5 6 7 8 9 10

**Did you go to the hospital?**  
- Yes  
- No

- If you went to the hospital, when?  
- Just after the accident  
- The next day

**How did you get to the hospital?**  
- Ambulance  
- Private Transportation

**Did the ambulance attendants place you in:**  
- neck collar  
- splints  
- brace

**Were you admitted to the hospital?**  
- Yes  
- No

- If yes, how long did you stay? ___________

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**PLEASE TURN OVER**
• Have you seen any other doctor as a result of this accident?  Yes  No
  Who and where? ________________________________________________

• Have you lost any time from work because of this accident?  Yes  No
  If yes, give dates of time lost.  From _________________________ to _________________________

• BEFORE YOUR ACCIDENT, estimate your total lifting effort ability: (FILL OUT IF THIS APPLIES TO YOUR WORK)
  1. How much weight?  ___ Maximum  ___ Average
  2. Was this lifting done at work?  Yes  No  Or at home or elsewhere?  Yes  No
  3. How often did you carry this amount of weight?  ________________________________________

• AFTER YOUR ACCIDENT, describe your total lifting ability: (FILL OUT IF THIS APPLIES TO YOUR WORK)
  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. Are you now limited in your total lifting ability in some body position that you were previously not?  Yes  No
     If so, specify position _____________________________________________
  4. What symptoms does lifting produce?  _______________________________________________________
  5. How long do these symptoms last?  ______________________

• Are you presently able to (MARK ONE IN EACH CATEGORY): (FILL OUT IF THIS APPLIES TO YOUR WORK)
  1. LIFT  ___ Very heavy ___ lbs.  ___ Heavy ___ lbs.  ___ Light ___ lbs.  ___ Sitting ___ lbs.
  2. WORK  ___ Very heavy ___ lbs.  ___ Heavy ___ lbs.  ___ Light ___ lbs.  ___ Sitting ___ lbs.

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

• Can you perform any physical work activity?  Yes  No
• Can you perform any mental work?  Yes  No

PLEASE FILL OUT THE QUESTIONS AS ACCURATELY AS POSSIBLE
• 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 the above functions due to:
  pain  weakness  structural limitations  nerves?

• Do you have normal sexual function?  Yes  No
• Are you able to take personal care of yourself, such as dressing, bathing, cleaning your house etc.?  Yes  No
  Or do you require assistance?  Yes  No

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

Patient's signature ___________________________ Date ______________________