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 the vehicle? ___ Driver ___ Passenger
If passenger, were you sitting in: ___ Front ___ Right Rear ___ Left Rear ___ Center Rear
Did your vehicle strike the other vehicle? ___ Yes ___ No Were airbag(s) deployed in either vehicle? ___Yes ___No
Was your vehicle struck by the 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? ___looking up / down?
Were both hands on steering wheel? ___ Yes ___ No Position: _____Was your foot on brake? ___ Yes ___ No
Were you braced for impact? ___ Yes ___ No Were you wearing seat belts? ___ Yes ___ No
Where in the vehicle were you after the accident? _____
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 ___ hand ___ head

Immediately following the accident how did you feel?_____
_____
Were you unconscious? ___ Yes ___ No In a daze? ___ Yes ___ No
Did you go to the hospital? ___ Yes ___ No
If you went to the hospital, when? ___ at time of accident ___ next day ___ other, please specify_____
How did you get to the hospital? ___ ambulance ___ private tranportation
Did the ambulance attendants place you in: ___ neck collar ___ splints ___ brace ___Backboard
Name of Hospital _____ Attended by Dr. _____
Were you X-rayed at the hospital? ___ Yes ___ No What parts? _____
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 ___ Lying on your right side ___ Lying on your left side
___ Lying on your back ___ On your stomach ___ Standing 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 legs? ___ Yes ___ No In arms? ___ 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 _____