

**PERSONAL INJURY  
WORKER'S COMPENSATION  
Questionnaire**

Name \_\_\_\_\_ File # \_\_\_\_\_ Date of Accident \_\_\_\_\_ Time \_\_\_\_\_

Where did accident happen? \_\_\_\_\_

Describe the accident in your own words: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PERTAINING TO AUTO:**

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 vehicles?  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  Other \_\_\_\_\_

Please state part of body:  Chest  Chin  Knee  Shoulder  Hand  Head  Other \_\_\_\_\_

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 Doctor \_\_\_\_\_ 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

On your left side?  Yes  No Lying on your back?  Yes  No On your stomach?  Yes  No

Standing?  Yes  No Other? \_\_\_\_\_

It is 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) relieve the pain?  Yes  No

Does a change in heel height worsen the pain?  Yes  No Do you feel better moving around?  Yes  No

Resting?  Yes  No Do you have a firm mattress?  Yes  No Do your knees ache or hurt?  Yes  No

Do you have cramps in leg?  Yes  No Do you have cramps 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 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? \_\_\_\_\_ 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?  Standing  Walking  Sitting  
 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 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 functions?  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 \_\_\_\_\_