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ACCIDENT (PI/WC) QUESTIONNAIRE

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Name: _____ Date of Injury: _____ Time_____
LAST *FIRST* *M.I.*

Where did the accident happen?_____

Describe the accident in your own words _____ _____

_____

_____

What was your position in the vehicle? ☐ Driver ☐ Passenger If Passenger, sitting: ☐ Front ☐ Right Rear ☐ Left Rear

Did your vehicle strike the other vehicle? ☐ Yes ☐ No

Was your vehicle struck by the other vehicle? ☐ Yes ☐ No

Was the impact from: ☐ Front? ☐ Right Side? ☐ Left Side? ☐ Rear?

At the time of impact were you: ☐ Looking straight ahead? ☐ Looking right? ☐ Looking left?

Were both hands on the steering wheel? ☐ Yes ☐ No Was your foot on the brake? ☐ Yes ☐ No

Were you braced for impact? ☐ Yes ☐ No Were you wearing your seat belt? ☐ Yes ☐ No

Where in the vehicle were you after the accident? _____

Did you strike anything in the vehicle at the time of impact?

Chest	☐ Steering Wheel	☐ Dashboard	☐ Windshield	☐ Side Door	☐ Arm Rests	☐ Side Window	☐ Other_____
Chin	☐ Steering Wheel	☐ Dashboard	☐ Windshield	☐ Side Door	☐ Arm Rests	☐ Side Window	☐ Other_____
Knee	☐ Steering Wheel	☐ Dashboard	☐ Windshield	☐ Side Door	☐ Arm Rests	☐ Side Window	☐ Other_____
Shoulder	☐ Steering Wheel	☐ Dashboard	☐ Windshield	☐ Side Door	☐ Arm Rests	☐ Side Window	☐ Other_____
Hand	☐ Steering Wheel	☐ Dashboard	☐ Windshield	☐ Side Door	☐ Arm Rests	☐ Side Window	☐ Other_____
Head	☐ Steering Wheel	☐ Dashboard	☐ Windshield	☐ Side Door	☐ Arm Rests	☐ Side Window	☐ Other_____

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 so, when? ☐ At time of accident ☐ Next day ☐ Other _____

How did you get to the hospital? ☐ Ambulance ☐ Private transportation ☐ N/A
Did the ambulance place you in a: ☐ Neck Collar ☐ Splints ☐ Brace

Name of Hospital _____ Attended by Dr. _____

Were x-rays done at the 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 physical therapy?	☐ Yes	☐ No
See orthopedic doctor?	☐ Yes	☐ No

Other _____

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No Doctor's Name _____

Are your symptoms ☐ Constant ☐ On & Off ☐ Sharp ☐ Dull ☐ Other _____

Do any of the following make your symptoms worse? (select one or more)

□ Arising from a chair	□ Bowel Movements	□ Coughing	□ Straining
□ Sneezing	□ Moving Around in Bed	□ Stretching	□ Twisting

Do you have numbness or tingling in any of the following areas? (check all that apply)

□ Arms	□ Hands	□ Fingers	□ Legs	□ Feet	□ Toes

Do you experience any cramps in your arms or legs? ☐ Yes ☐ No Any change in bowel habits? ☐ Yes ☐ No

Do any of the following make your symptoms better? (select one or more)
□ Heating pad □ Hot bath □ Shower □ Ice Pack
□ Brace □ Moving Around □ Firm Mattress □ Resting

Most comfortable position ☐ Sitting ☐ Standing ☐ Lying on Stomach ☐ Lying on Back ☐ Lying on Rt ☐ Lying on Lt ☐ Other___

Have you lost any time from work due to this accident? ☐ Yes ☐ No If yes, give dates of time lost _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

BEFORE YOUR ACCIDENT, estimate your total lifting effort ability:
Maximum weight _____ Average weight _____ How far could you carry _____ For how long _____

Was this lifting done at work? ☐ Yes ☐ No At home? ☐ Yes ☐ No
How often did you carry this amount of weight? _____

AFTER YOUR ACCIDENT, describe your total lifting ability WITHOUT EXPERIENCING PAIN, DISCOMFORT OR RESTRICTION OF MOTION:
Maximum weight _____ Average weight _____ How far can you carry _____ For how long _____
How often can you carry this amount of weight? _____

Did you experience this pain, discomfort or restriction of motion before your accident? ☐ Yes ☐ No

Are you now limited in your total lifting ability in a body position that you were previously not? ☐ Yes ☐ No
If so, specify position _____

What symptoms does lifting produce? _____ How long do symptoms last? _____

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

With minimum demand of physical effort, what positions can you work in PART-TIME and for how long?
Standing _____ Sitting _____ Walking _____

With a minimum demand of physical effort, can you work in a sitting position with some degree of walking or standing activity?
☐ Yes ☐ No Explain _____

Do you feel that you cannot perform any physical work activity? ☐ Yes ☐ No Any mental work activity? ☐ Yes ☐ No

Relate your BEFORE injury capacity (mark "B") and your AFTER injury capacity ("A") for performing activities:

Walking	Normal _____	Limited _____	Difficult _____	Pain _____
Standing	Normal _____	Limited _____	Difficult _____	Pain _____
Sitting	Normal _____	Limited _____	Difficult _____	Pain _____
Bending	Normal _____	Limited _____	Difficult _____	Pain _____
Stooping	Normal _____	Limited _____	Difficult _____	Pain _____
Lifting	Normal _____	Limited _____	Difficult _____	Pain _____
Pushing	Normal _____	Limited _____	Difficult _____	Pain _____
Pulling	Normal _____	Limited _____	Difficult _____	Pain _____
Climbing	Normal _____	Limited _____	Difficult _____	Pain _____
Reaching	Normal _____	Limited _____	Difficult _____	Pain _____
Gripping	Normal _____	Limited _____	Difficult _____	Pain _____
Kneeling	Normal _____	Limited _____	Difficult _____	Pain _____
Balance	Normal _____	Limited _____	Difficult _____	Pain _____
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 personal care of yourself such as dressing, bathing, etc.? ☐ Yes ☐ No
Or do you require assistance? ☐ Yes ☐ No

Do you feel your present condition is ☐ Temporary ☐ Permanent

_____

Parent(s)/Guardian(s) Signature

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HEALING FROM THE INSIDE OUT