Personal Injury/Workers Compensation Questionnaire

Name_____ Date of Accident_____ Time_____

Where did it happen? _____

Describe the accident in your own words:

_____

_____

Where you the ☐ driver ☐ passenger? If passenger, were you sitting in ☐ front, ☐ rear right ☐ rear left

Did your vehicle strike another vehicle? ☐ Yes ☐ No Was your vehicle struck by another? ☐ Yes ☐ No

Was the impact from the: ☐ front? ☐ the rear? ☐ the right side? ☐ The left side?

At the time of the impact were you looking: ☐ forward? ☐ to the left? ☐ to the right?

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

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

Did you strike anything in the vehicle? ☐ Yes ☐ No If yes, what: _____

Immediately after the accident, how did you feel? _____

Were you unconscious? ☐ Yes ☐ No Were you in a daze? ☐ Yes ☐ No Did you go the hospital? ☐ Yes ☐ No

If yes, when did you go to the hospital? _____ How did you get to the hospital?_____

Name of hospital? _____ Did they take X-Rays/MRIs? ☐ Yes ☐ No Which: _____

What did they diagnose you with? _____

What treatment did they do? _____

Did they admit you overnight? ☐ Yes ☐ No If yes, for how long: _____

What other recommendations were made? _____

Did you see any other doctors? ☐ Yes ☐ No If yes, which: _____

Have you lost any time from work for this accident? ☐ Yes ☐ No If yes, what dates have you lost?

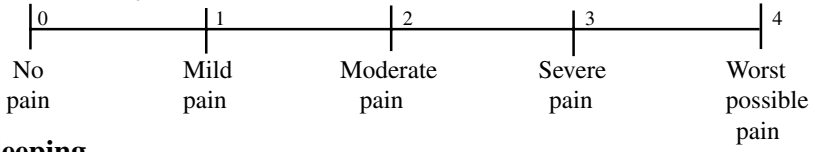
From _____ To _____ Partially Disabled? ☐ Yes ☐ No Fully Disabled? ☐ Yes ☐ No

Functional Rating Index

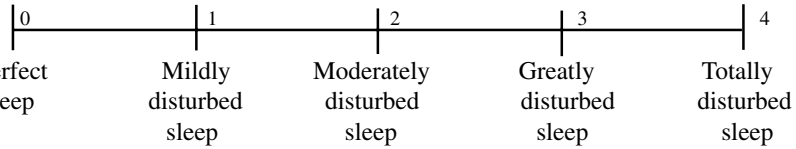
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

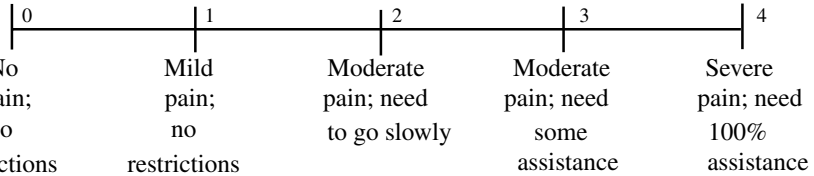
1. Pain Intensity



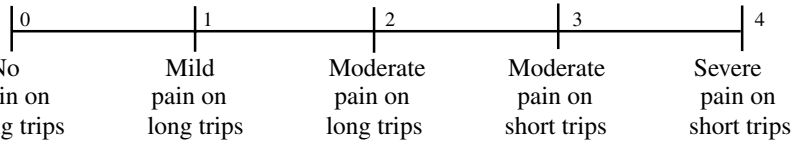
2. Sleeping



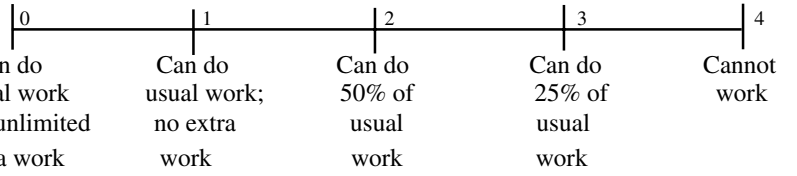
3. Personal Care (washing, dressing, etc.)



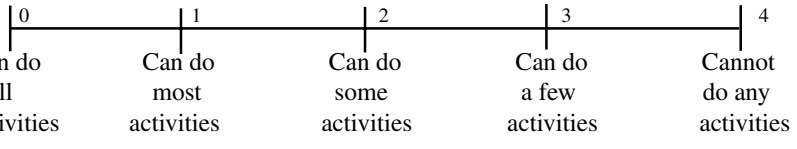
4. Travel (driving, etc.)



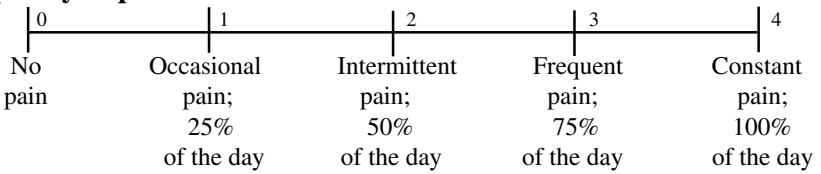
5. Work



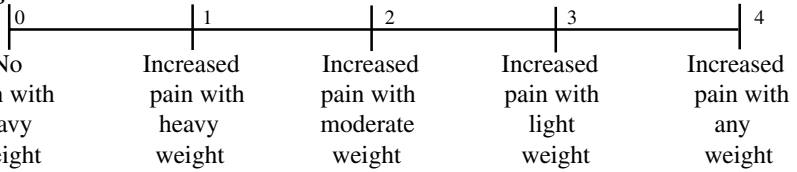
6. Recreation



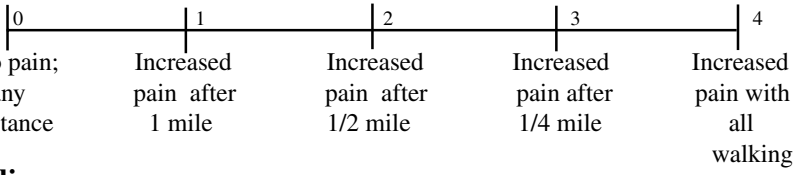
7. Frequency of pain



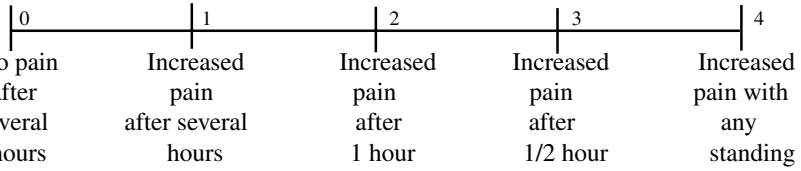
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date