

# PERSONAL INJURY QUESTIONNAIRE

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ S/S # \_\_\_\_\_

Employer's Name \_\_\_\_\_ Employer's Address \_\_\_\_\_

Your Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Agent's Name \_\_\_\_\_

Name on Policy (If other than self) \_\_\_\_\_ Policy # \_\_\_\_\_

Responsible Party's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy # \_\_\_\_\_

## ATTORNEY

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Were there any witnesses? ( ) Yes ( ) No Name(s) \_\_\_\_\_

## NATURE OF ACCIDENT:

1. Date of Accident \_\_\_\_\_ Time of Day \_\_\_\_\_

2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

3. Number of people in your vehicle? \_\_\_\_\_ Were you wearing seat belts? \_\_\_\_\_

4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West  
on (name of street) \_\_\_\_\_

5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West  
on (name of street) \_\_\_\_\_

6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side

7. Approximate speed of your car \_\_\_\_\_ mph Other car \_\_\_\_\_ mph

8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? \_\_\_\_\_

9. Were police notified? ( ) Yes ( ) No

10. In your own words, please describe accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail:  
\_\_\_\_\_  
\_\_\_\_\_

12. Please describe how you felt:

a. DURING the accident: \_\_\_\_\_

b. IMMEDIATELY AFTER the accident: \_\_\_\_\_

c. LATER THAT DAY: \_\_\_\_\_

d. THE NEXT DAY: \_\_\_\_\_

13. What are your PRESENT complaints and symptoms? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

16. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. Where were you taken after the accident? \_\_\_\_\_

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address: \_\_\_\_\_  
\_\_\_\_\_

What type of treatment did you receive? \_\_\_\_\_  
\_\_\_\_\_

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Numbness in Toes    | <input type="checkbox"/> Face Flushed    | <input type="checkbox"/> Feet Cold     |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold    |
| <input type="checkbox"/> Neck Stiff        | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Too Heavy   | <input type="checkbox"/> Depression          | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes  | <input type="checkbox"/> Loss of Smell   | <input type="checkbox"/> Cold Sweats   |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory      | <input type="checkbox"/> Loss of Taste   | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Ears Ring           | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> _____         |

Symptoms Other Than Above \_\_\_\_\_

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question.

a. Last Day Worked: \_\_\_\_\_

b. Type of Employment: \_\_\_\_\_

c. Present Salary: \_\_\_\_\_

d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving: \_\_\_\_\_  
\_\_\_\_\_

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe, in detail:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. Other pertinent information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE

PATIENT'S SIGNATURE

# Oswestry Disability Index

This questionnaire has been designed to give the doctor information as to how your pain or condition has affected your ability to manage everyday life. Please answer every section and circle in each section **only the ONE number** that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just circle the number that most closely describes your problem.

## Section 1: Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is very severe.
5. The pain is severe and does not vary much.

## Section 2: Personal Care

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increases the pain, but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain, I am unable to do some washing and dressing without help.
5. Because of the pain, I am unable to do any washing and dressing without help.

## Section 3: Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it causes extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
3. Pain prevents me from lifting heavy weights off the floor.
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at the most.

## Section 4: Walking

0. I have no pain on walking.
1. I have some pain on walking, but it does not increase with distance.
2. I cannot walk more than one mile without increasing pain.
3. I cannot walk more than 1/2 mile without increasing pain.
4. I cannot walk more than 1/4 mile without increasing pain.
5. I cannot walk at all without increasing pain.

## Section 5: Sitting

0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than one hour.
3. Pain prevents me from sitting more than 1/2 hour.
4. Pain prevents me from sitting more 10 minutes.
5. I avoid sitting because it increases pain right away.

- 0-10 Minimal disability  
11-20 Moderate disability  
21-30 Severe disability  
31-40 Crippled (incapacitated)  
40-50 Bed-bound

## Section 6: Standing

0. I can stand as long as I want without pain.
1. I have some pain on standing, but it does not increase with time.
2. I cannot stand for longer than one hour without increasing pain.
3. I cannot stand for longer than 1/2 hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain right away.

## Section 7: Sleeping

0. I get no pain in bed.
1. I get pain in bed, but it does not prevent me from sleeping well.
2. Because of pain, my normal night's sleep is reduced by less than 1/4.
3. Because of pain, my normal night's sleep is reduced by less than 1/2.
4. Because of pain, my normal night's sleep is reduced by less than 3/4.
5. Pain prevents me from sleeping at all.

## Section 8: Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal, but increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

## Section 9: Traveling

0. I get no pain while travelling.
1. I get some pain while travelling, but none of my usual forms of travel makes it any worse.
2. I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
3. I get extra pain while travelling, which compels me to seek alternative forms of travel.
4. Pain restricts all forms of travel.
5. Pain prevents all forms of travel except that done lying down.

## Section 10: Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates, but is definitively getting better.
2. My pain seems to be getting better, but improvement is slow at present.
3. My pain is neither getting better nor worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Patient's Signature:

\_\_\_\_\_

Date: \_\_\_\_\_