PATIENT NAME: _____

SINCE THE ACCIDENT IS THE PATIENT:
☐BETTER ☐SAME ☐WORSE

HAS THE PATIENT LOST TIME FROM WORK? ☐YES ☐NO

IF YES, FOR HOW LONG? _____

CAN PERFORM PHYSICAL WORK ACTIVITIES? ☐YES ☐NO

IF NO, WHY? ☐PAIN ☐WEAKNESS ☐STRESS

OTHER: _____

SINCE THE ACCIDENT HAS HAD PROBLEMS WITH:

☐SEEING ☐TASTING ☐SMELLING ☐EATING

☐HEARING ☐BATHING ☐GROOMING ☐DRESSING

☐READING ☐TYPING ☐WRITING ☐GRASPING

☐HOLDING ☐PINCHING ☐STANDING ☐LEANING

☐WALKING ☐STOOPING ☐SQUATTING ☐CLIMBING

☐KNEELING ☐BENDING ☐TWISTING ☐CARRYING

☐LIFTING ☐PUSHING ☐PULLING ☐REACHING

☐SITTING ☐DRIVING ☐RIDING CAR ☐PLANE TRAV.

☐SPORTS ☐EXERCISING ☐LOSS OF SEXUAL DRIVE

☐RECLINING ☐RESTFUL SLEEPING

☐INSOMNIA ☐USING THE TOILET

☐LOSS OF CONCENTRATION ☐NERVOUS ☐IRRITABLE

☐CHANGE IN PERSONALITY ☐TACTILE FEELING

CAN GO TO SLEEP WITHOUT PROBLEMS? ☐YES ☐NO

AWAKEN BECAUSE OF PAIN? ☐YES ☐NO

IF YES, WHERE? _____

HAD SLEEP PROBLEMS BEFORE? ☐YES ☐NO

PATIENT'S OCCUPATION: _____

DUTY: ☐LIGHT DUTY
☐REGULAR DUTY

FINANCIAL BURDEN FOR PATIENT AND FAMILY? ☐YES ☐NO

IF YES, PATIENT EXPLAINS: _____

_____

HAS BEEN IN AN ACCIDENT BEFORE? ☐YES ☐NO

IF YES, IN (YEAR) _____

DOCTOR WHO TREATED, DR. ☐YES ☐NO

DETAILS: _____

_____

ANY RESIDUAL PROBLEMS? ☐YES ☐NO

EXPLAIN: _____

_____

SECOND ACCIDENT

IF YES, IN (YEAR) _____

DOCTOR WHO TREATED, DR. _____

DETAILS: _____

_____

ANY RESIDUAL PROBLEMS? ☐YES ☐NO

EXPLAIN: _____

_____

THIRD ACCIDENT

IF YES, IN (YEAR) _____

DOCTOR WHO TREATED, DR. _____

DETAILS: _____

_____

ANY RESIDUAL PROBLEMS? ☐YES ☐NO

EXPLAIN: _____

_____