

QUESTIONNAIRE



This report is intended to concentrate on the effects of the accident, and not the accident itself.

I will dictate your report at the time of your interview to ensure accuracy.

FULL NAME						
DATE OF BIRTH			AGE			
OCCUPATION						
Tick as appropriate	Right handed		Left handed		Married	
	Single		Divorced		Widow	
	Widower		Living with Partner			
DATE OF INJURY			TIME OF INJURY			

ROAD TRAFFIC ACCIDENT (ignore this section if not applicable)

Your position in the vehicle at time of accident

Moving or stationary at the time of impact?

What was the position of your car at the time of the accident? (i.e. were you at traffic lights, at a junction or moving)

Were there any other passengers in your car Yes/No

If yes, where were they sitting?

Were you wearing a seat belt at the time of the accident? Yes/No

Did your car have headrests in place? Yes/No Did your car have airbags Yes/No

Did you have any warning? Yes/No If so were you able to brace yourself? Yes/No

Were you able to take evasive action? Yes/No

Did any part of your body impact with any other part of the vehicle? Yes/No

What part(s) of your body were hit, and by what? (please be brief)

What happened to you as a result of the impact?

(E.g. were you thrown forwards or backwards, or forward then backwards or vice versa?)

MOVEMENT AFTER ACCIDENT AND MEDICAL ATTENDANCE

Did you receive medical attention at the scene of the accident? Yes/No

Did you attend a hospital for treatment? Yes/No If yes, which one?

How did you get there?

Were you examined? Yes/No

Were X-rays taken? Yes/No

If yes, of what areas?

What did they say was wrong with you? (E.g. whiplash, concussion, sprain etc)

What drugs were you given?

Were you given any specific advice, either written or verbal?

Were you given a neck collar? Yes/No

Were you told to come back to hospital for follow up, or to see your GP?

Did you see your own GP after the accident? Yes/No

If yes, on what dates?

If yes, were you examined?

Was the diagnosis confirmed?

Was any other diagnosis made?

Were any X-rays or other investigations organised?

Were you prescribed any drugs?

Were you issued with a medical certificate/sick note? Yes/No If yes, from what dates?

Were you referred for any other treatment? (E.g. physiotherapy)

If yes, have you been seen yet? Yes/No

If you have been seen, how many treatments have you had?

How many more treatments are planned?

INJURIES SUSTAINED

Which parts of your body were injured?
(E.g. neck, head, back, shoulders)

For each area injured:- (you will need to write the answers to these questions on the other side of this paper if there are more than one areas)

How long after the accident did the pain start?

Was it mild, moderate, or severe?

Did it get worse, and if so, over what period of time?

Was the area stiff as well?

Did the pain radiate anywhere?

Did you take any painkillers?

Did the pain stop you from sleeping?

How long did it last before there was any improvement?

Do you still suffer from pain?

If yes, is it present all the time, or intermittently?

What makes it worse?

Do you take any painkillers at present?

Do you continue to suffer from difficulty sleeping because of pain?

Do your symptoms of pain/discomfort cause you any significant inconvenience?

PSYCHOLOGICAL INJURY

Immediately after the accident, were you:

shaken	upset	shocked
crying	disorientated	physically shaking
nauseated	vomiting	

How long did this last?

In the following days, did you suffer from:- (if yes, please indicate for how long)

- Nightmares relating to the accident
- Flashbacks
- Constant preoccupation with the accident
- Difficulty sleeping (not because of pain)

Since the accident have you:- (if yes, please indicate for how long)

- Been depressed?
- Suffered from low mood?
- Received any treatment for depression?

Since the accident, as a driver:-

Have you been more nervous?

Do you drive more slowly?

Do you use your rear view mirrors more?

Are you more aware of the movements of other vehicles?

Are there any particular situations when driving that make you tense or nervous?

Are you actually more nervous as a driver, or just more wary?

Since the accident, as a passenger?

- Are you more nervous?
- Do you grip the sides of the seat or door handles?
- Do you use imaginary brakes?
- Are you constantly watching the movements of other vehicles?
- Do you advise and criticise the driver?

TIME OFF WORK

How long did you have off work?

Did your GP certify you off work because of this injury? Yes/No

If yes, how many certificates did you need, and from which dates?

When did you return to work?

Did you return to light or altered duties? (If so for how long?)

Are you able to carry out your normal employment?

Are there any limitations?

Have any special arrangements been made for you at work?

EFFECT ON SOCIAL/RECREATIONAL ACTIVITY

Did any planned social events have to be cancelled?
(E.g. weddings, parties, holidays)

Was your enjoyment of any planned social events affected?

What are your hobbies or do you participate in any sports?

Prior to the accident how often did you do this?

How long were you unable to after the accident?

Are you still unable?

EFFECT ON DOMESTIC LIFE

Were there any tensions within your relationship as a result of this accident?

Did your sex life suffer?

What domestic chores do you normally do?
(E.g. cooking, cleaning, washing clothes, ironing, hoovering, shopping, etc.)

Which of these chores did you find difficult, and are they still difficult?

PAST MEDICAL HISTORY

Are you normally healthy? Yes/No

Do you have any ongoing medical problems?

Are you taking any regular medication?

Were you taking any medication at the time of the accident?

Do you have any history of neck, back, or shoulder problems?

Have you any history of depressive illness, or other psychological problems?

Have ever sustained an injury in a road accident before? Yes/No

Have you previously suffered a similar injury, or made a similar claim? Yes/No

STATEMENT OF TRUTH

"I believe the facts stated in this document comprising 6 pages are true."

SIGNED.....

PRINT NAME.....

DATE.....

Please do not fill in this section

Neck		Back	
Skin		Skin	
Lordosis		Lordosis	
Spinous Processes		Spinous Processes	
Trigger Points		Trigger Points	
Flexion		Flexion	
Extension		Extension	
R Rotation		R Rotation	
L Rotation		L Rotation	
R Flexion		R Flexion	
L Flexion		L Flexion	
Neuro signs		Neuro signs	
		Squat	
		SLR	