Medical Report Questionnaire

Please complete this proforma as fully as possible and bring it with you when you attend for your appointment. Please also click the SUBMIT button at the end so that it can be emailed back to us.

Title

Surname

First names(s)

Address

Post Code

Date of Birth Age (years)

Telephone numbers Home

Work

Mobile

Occupation

Number of hours per week Full time Part time

Job duties (including standing, sitting, lifting, driving etc)

Marital status Number of children & ages

Type of accommodation House Flat Bungalow Other

Owner

DATE OF EXAMINATION:

DATE OF ACCIDENT
(incl. day)

WAS ACCIDENT RELATED TO YOUR JOB? Yes No

IF ROAD TRAFFIC ACCIDENT,WERE YOU: Driver Passenger

BRIEF CIRCUMSTANCES OF ACCIDENT:

WERE YOU WEARING A SEATBELT? Yes No

DID THE CAR HAVE HEAD RESTS? Yes No

WERE YOU KNOCKED OUT? Yes No

HOW LONG AFTER THE ACCIDENT DID YOU DEVELOP SYMPTOMS?

WHERE WAS THE PAIN?

DID YOU HAVE ANY PINS AND NEEDLES, IF SO WHERE AND FOR HOW LONG?

DID YOU ATTEND A HOSPITAL? Yes No

IF SO WHICH ONE AND WHEN?

HOW DID YOU GET TO HOSPITAL?

WERE X-RAYS TAKEN AND OF WHICH PART OF YOU?

WHAT DID THE HOSPITAL DOCTOR SAY WAS THE DIAGNOSIS?

WERE YOU ADMITTED TO HOSPITAL AND FOR HOW LONG?

WHAT DID THE HOSPITAL DOCTORS GIVE YOU WHEN YOU LEFT? (collar / tablets / advice)

DID THE HOSPITAL OR GP ARRANGE ANY TREATMENT AND IF SO HOW MANY TIMES DID YOU GO?

DID TREATMENT HELP?

HOW DID YOU SLEEP THE FIRST NIGHT AFTER THE ACCIDENT?

WHAT WERE THE SYMPTOMS THE FOLLOWING MORNING?

HOW MANY DAYS LATER DID YOU GO TO SEE YOUR GP?

DID THE GP ARRANGE ANY TREATMENT OR TESTS?

WHAT DIAGNOSIS DID THE GP GIVE YOU?

DID THE GP SIGN YOU OFF WORK AND FOR HOW LONG?

HOW SOON AFTER THE ACCIDENT WERE YOU ABLE TO LEAVE THE HOUSE?

WHICH OF YOUR PAINS BECAME BETTER FIRST AND AFTER HOW LONG?

HOW LONG DID YOU HAVE CONSTANT (ALL THE TIME) PAIN FOR?

WORK ASPECTS

WHAT DO YOU DO AT WORK?

HOW LONG AFTER ACCIDENT DID YOU RETURN TO WORK?

DID YOU RETURN TO FULL DUTIES OR WAS YOUR JOB MODIFIED INITIALLY AND IF SO, FOR HOW LONG?

WHAT ASPECTS OF WORK WERE NOT POSSIBLE INITIALLY AND FOR HOW LONG?

HOW LONG BEFORE YOU COULD PERFORM FULL DUTIES?

DO YOU HAVE ANY LIMITATIONS OR DIFFICULTIES AT WORK DUE TO THE CURRENT ACCIDENT?

HAVE YOU HAD TO CHANGE YOUR JOB AND IF SO, TO WHAT?

DOMESTIC ASPECTS

WHAT DOMESTIC ACTICITIES WERE IMPOSSIBLE OR PAINFUL?
(Please indicate which were **I**mpossible by marking an **I**, and **P**ainful with a **P**
For each activity you mark please state for how long the activity was impossible or painful).

Shopping (groceries)		Light cleaning	
Washing up		Reaching high shelves	
Ironing		Washing hair	
Cooking		Brushing teeth	
Any other activity			

At what stage did you start any of the above activities again?

SOCIAL ACTIVITIES

WHAT HOBBIES DID YOU HAVE PRIOR TO THE ACCIDENT? (Please tick relevant ones and indicate how often these activities were undertaken per month).

Aerobics			Swimming		
Weight Training			Squash		
Tennis			Football		
Rugby			Disco / Ballroom dancing		
Basketball			Needlework		
DIY			Gardening		

WERE ANY OF THESE ACTIVITIES NOT POSSIBLE BECAUSE OF THE INJURY AND IF SO FOR HOW LONG?

HAVE YOU RETURNED TO ANY OF THESE ACTIVITIES AND IF SO WHEN?

CURRENT STATE

WHICH OF THE SCORES BELOW COINCIDES WITH YOUR SYMPTOMS NOW?

10 / 10 - I can do everything without pain or limitation

9 / 10 - I can do everything but with some pain

8 / 10 - There are a few things I cannot do due to pain (specify)

7/ 10 - The are quite a few things I cannot do due to pain (specify)

0 - 6/ 10 - Significant handicap

THIS IS BECAUSE I STILL HAVE THE FOLLOWING SYMPTOMS:

WHAT THINGS ARE POSSIBLE NOW BUT ARE STILL PAINFUL?

WHAT THINGS ARE NOT POSSIBLE?

PREVIOUS MEDICAL HISTORY

HAVE YOU EVER INJURED OR HAD PROBLEMS WITH THE AREA YOU INJURED IN THE ACCIDENT?

IF YES, GIVE DETAILS:

HAD ALL THE SYMPTOMS SETTLED FROM THAT INJURY?

IF YES, GIVE DETAILS:

HAVE YOU EVER BEEN INVOLVED IN A WORK OR ROAD TRAFFIC ACCIDENT BEFORE?

IF YES, GIVE DETAILS AND STATE WHETHER IT WAS THE SUBJECT OF LEGAL COMPENSATION?

HAVE YOU EVER SEEN YOUR GP WITH A SIMILAR COMPLAINT OR PAIN IN THE SAME AREA BEFORE THE ACCIDENT (failure to disclose this may invalidate your claim).

IF YES, GIVE DETAILS:

DO YOU SUFFER FROM ANY MEDICAL / PSYCHIATRIC PROBLEMS, PRESENT OR PAST?

IF YES, GIVE DETAILS:

ARE YOU TAKING ANY MEDICATION, IF SO WHICH AND WHAT DOSES?

IF YES, GIVE DETAILS:

ANY ALLERGIES ?

DO YOU SMOKE, IF SO HOW MANY?

DO YOU DRINK ALCOHOL, IF SO HOW MUCH PER WEEK?

IT IS VITAL THAT ALL RELEVANT PREVIOUS ATTENDANCES ARE DISCLOSED NOW. FAILURE TO DO SO MAY INVALIDATE YOUR CLAIM, AS ALL PARTIES WILL HAVE ACCESS TO YOUR GP AND HOSPITAL RECORDS.

PLEASE GIVE DETAILS OF ANYTHING FELT TO BE OF RELEVANCE NOT ASKED ELSEWHERE:

PSYCHOLOGICAL ASPECTS

DO YOU WISH ANY OF THE FOLLOWING TO BE INCLUDED IN YOUR REPORT? If so please give details in the appropriate boxes.

Depression

Sleep disturbances / bad dreams

Tearfulness

Anxiety when driving

Alterations in sex life

Alterations of relations with family / friends / partner

Thank you for your time and co-operation.
Please print this out and post back to us OR click the SUBMIT button to email it to us. SUBMIT

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