BEFORE AND AFTER ACCIDENT/INJURY QUESTIONNAIRE

Name:____________________________________ **Date :**___________________

1. Before your accident/injury, estimate your total lifting ability:
    1. How much weight? Maximum:__________lbs. Average:__________lbs.
    2. How far did you carry this weight?__________ How long of time?__________
    3. Did this involve: ☐ Work lifting? ☐ Personal lifting?
    4. How often did you carry this amount of weight?______________________________
    5. Was there a particular body position involved? ☐ Yes ☐ No If yes, please describe:____

2. After your accident/injury, describe your total lifting ability:
    1. How much weight can you now lift without pain, discomfort or restriction of motion?__________
    2. Did you experience this pain, discomfort, restriction of motion before your accident/injury? ☐ Yes ☐ No
    3. How far can you carry this weight?__________ For how long a time?__________
    4. How often can you carry this weight?____________________________________
    5. Are you now limited in your lifting in some body position that previously you were not? ☐ Yes ☐ No If yes, what position(s)?__________________________________
    6. What symptoms does lifting produce?_______________________________________
    7. How long do these symptoms last?____

3. How much are you able to lift? Very heavy_____lbs. Heavy_____lbs. Light_____lbs.

4. What position(s) can you work in with a MINIMUM DEMAND of physical effort?
   ☐ Standing ☐ Walking ☐ Sitting

5. With MINIMUM DEMAND of physical effort, what position(s) can you work in PART TIME and for how long? ☐ Standing ☐ Walking ☐ Sitting Length of time __________

6. With MINIMUM DEMAND of physical effort, can you work in a SITTING POSITION with some walking or standing permitted?____

7. Do you feel that you CANNOT DO ☐ Most physical work? ☐ Most mental work?

8. What percentage of the time are you: Bedfast___% Chairbound___% Housebound___%

9. Generally speaking, is your disability caused by: ☐ Pain ☐ Weakness ☐ Structural limitations ☐ Mental Disorders

10. Check off the following work conditions that best describe what you feel you are capable of working under: ☐ Heavy ☐ Moderate ☐ Light ☐ While Sitting ☐ Full time ☐ Part time ☐ Not able to work at all

11. Can you perform any of your required work functions with the aid of an ORTHOPEDIC APPLIANCE such as a back brace or neck collar? ☐ Yes ☐ No ☐ Unsure
    If yes, please describe the type of support which eases your pain: ____________________
    ____

12. Do you feel your present condition is: ☐ Temporary ☐ Permanent ☐ Don't know

13. Describe the activities you could do before the accident/injury, but cannot do now:

____

14. Describe the activities you can now only do a little of compared to before the accident/ injury:____

15. Describe the activities you don't even think about doing since the accident/injury:

____

16. Describe your BEFORE accident/injury capacity for performing such activities as:

WALKING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
STANDING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
SITTING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
BENDING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
STOOPING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
LIFTING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
PUSHING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
PULLING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
CLIMBING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
REACHING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
GRIPPING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
KNEELING OR STOOPING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
BALANCE	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
FATIGUE OR EXHAUSTION	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____

10. Describe your AFTER accident/injury capacity for performing such activities:

WALKING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
STANDING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
SITTING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
BENDING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
STOOPING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
LIFTING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
PUSHING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
PULLING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
CLIMBING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
REACHING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
GRIPPING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
KNEELING OR STOOPING	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
BALANCE	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____
FATIGUE OR EXHAUSTION	NORMAL____	LIMITED____	DIFFICULT____	PAINFUL____

Patient's Signature:________________________________ Date: ________________

Witness:____ Date: ________________

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