

**Personal Injury/Workers' Compensation
Application for Care**



Name: _____ Date of accident: _____ Time: _____
Where did accident happen? _____
Describe the accident in your own words: _____

What was your position in the car? Driver Passenger If passenger, were you sitting in Front Right Rear Left Rear
Did your vehicle strike another vehicle? Yes No Was your car struck by another vehicle? Yes No
Was the impact from: the front? from the right side? from the left side? from the rear?
At the time of impact were you: looking straight ahead? looking right? looking left?
Were both hands on the steering wheel? Yes No Was your foot on the brake? Yes No
Were you braced for impact? Yes No Where were you in the car after the accident? _____
Were you wearing a seatbelt? Yes No Did you strike anything in the vehicle at the time of impact? Yes No
If yes, specify: Steering Wheel Dashboard Windshield Side Door Arm Rests Side Window
Please state part of body that hit: Chest Chin Knee Shoulder Hand Head
Immediately following the accident how did you feel? _____

Were you unconscious? Yes No In a daze? Yes No Did you go to the hospital? Yes No
If you went to the hospital, when? At time of accident Yes No Next day Yes No
How did you get to the hospital? Ambulance Yes No Private transportation Yes No
Did the ambulance attendants place you in: Neck Collar Yes No Splints: Yes No Brace: Yes No
Name of Hospital: _____
Attended by Dr. _____ Were you x-rayed at the hospital? Yes No
Is so, what was the diagnosis? _____
Were you admitted to the hospital? Yes No How long did you stay? _____
What treatment was rendered? _____

What recommendations were made? See own doctor? Yes No See orthopedic doctor? Yes No
Physical Therapy? Yes No
Have you seen any other doctor as a result of this accident? Yes No
Doctor's Name _____
Is your pain constant? Yes No Is the pain on and off? Yes No Sharp? Yes No Dull? Yes No
Other _____

Is your pain worse when arising from a chair? Yes No Is it made worse by straining Yes No By coughing? Yes No
By sneezing? Yes No By straining when moving your bowels? Yes No
Do you have a numbness or tingling in your arms? Yes No In your hands? Yes No In your fingers? Yes No
In your legs? Yes No In your feet? Yes No In your toes? Yes No
What is your most comfortable position? Sitting Yes No Lying on your right side Yes No Lying on left side? Yes No
Lying on back Yes No On your stomach Yes No Standing Yes No
Other _____ Is it difficult for you to move around in bed? Yes No
Does stretching and twisting worsen the pain? Yes No
Do any of the following relieve your pain? Heating pad Hot Bath Shower Ice Pack
Does a brace (if you have tried one) help to relieve the pain? Yes No
Does a change in heel height worsen the pain? Yes No Do you feel better moving around? Yes No Resting? Yes No
Do you have a firm mattress? Yes No Do your knees ache or hurt? Yes No Do you have cramps in your leg? Yes No
In arm? Yes No Have you had any change in your bowel habits? Yes No

Have you lost any time from work because of this accident? Yes No
If yes, give dates of time lost. From _____ to _____
Totally disabled from _____ to _____ Partially disabled from _____ to _____

BEFORE YOUR ACCIDENT, estimate your total lifting effort ability:

1. How much weight? Maximum Average
2. How far could you carry this weight? _____ For how long? _____
3. Was this lifting done at work? Yes No Or at home or elsewhere? Yes No
4. How often did you carry this amount of weight? _____

AFTER YOUR ACCIDENT, describe your total lifting ability:

1. How much weight can you now lift without experiencing pain, discomfort or restriction of motion? _____
2. Did you experience this pain, discomfort or restriction of motion before your accident? Yes No
3. How far can you carry this weight now? _____ And for how long? _____
4. How often can you carry this weight? _____
5. Are you now limited in your lifting ability in some body position that you were previously not? Yes No
If so, specify position _____
6. What symptoms does lifting produce? _____
7. How long do these symptoms last? _____

Are you presently able to:

LIFT Very Heavy _____ lbs. Heavy _____ lbs. Light _____ lbs. Sitting _____ lbs.
 WORK Very Heavt _____ lbs. Heavy _____ lbs. Light _____ lbs. Sitting _____ lbs.

What positions can you work in with a MINIMUM DEMAND of physical effort? _____

With Minimum Demand of physical effort, what positions can you work in PART-TIME and for how long?

Standing Walking Sitting

With Minimum Demand of physical effort, can you work in a SITTING POSITION with some degree of walking or standing activity? YES No

Do you feel that you cannot perform any physical work activity? Yes No

Do you feel that you cannot perform any mental work? Yes No

Relate your BEFORE injury capacity (mark B) and your AFTER injury capacity (mark A) for performing activities:

- | | | | | |
|-------------|--------------|---------------|-----------------|------------|
| 1.Walking | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 2.Standing | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 3.Sitting | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 4.Bending | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 5.Stooping | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 6.Lifting | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 7.Pushing | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 8.Pulling | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 9.Climbing | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 10.Reaching | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 11.Gripping | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 12.Kneeling | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 13.Balance | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 14.Fatigue | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |

Generally speaking, is your inability to perform these functions due to Pain Weakness Structural limitations Nerves

Do you have normal sexual function? Yes No

Are you able to take care of your personal self, such as dressing, bathing, etc? Yes No

Or do you require assistance? Yes No

Do you feel your present condition is temporary? Yes No or permanent? Yes No

Patient's Signature _____ Date: _____