PLEASE TAKE THIS FORM WITH YOU WHEN ATTENDING YOUR APPOINTMENT WITH OUR EXPERT.

DOCTORS CHAMBERS GROUP

Injury Questionnaire

The person who signs this form must be over the age of 16.
If you are completing this form on behalf of someone, what is your relationship to the injured person?

Parent / Guardian / Friend / Other *(please specify)* .....

NAME OF INJURED ..... **DATE OF BIRTH** .....

ADDRESS .....

..... **POSTCODE** .....

TELEPHONE NO ..... *(HOME)* ..... *(WORK)*

MOBILE NO ..... **EMAIL** .....

BACKGROUND OF INJURED PERSON

1 Are you? Right handed ❒ Left handed ❒

2 Marital status: Married ❒ Single ❒ Divorced ❒
Widow ❒ Widower ❒ Other: .....

3 Do you have any children? Yes ❒ No ❒ (Go to 4)
If yes, how many? ..... How old are they? .....

4 What is your current occupation? .....
Who do you work for? Self employed ❒ Name of employer: .....

5 How long have you held this job? .....

6 What special skills do you possess? *(especially those that may be affected by the injuries you have sustained)*

.....

.....

.....

INJURY DETAILS

7 Date of injury: ..... Time of injury: .....

Please describe (briefly) the accident or the incident that caused the injuries:
(what part of your body was hit,by what and how?)

.....

.....

.....

8 Type of injury? Road Traffic Accident ❒ (Go to 9)
Injury at work ❒ (Go to 16)
Tripping / Slipping ❒ (Go to 16)
Other *(specify)*: ..... (Go to 16)

ROAD TRAFFIC ACCIDENT

(if your injuries were not caused by a road traffic accident, go to the next section)

9 Your position in the vehicle at time of accident:

driving seat ❒ front seat passenger ❒

back seat passenger ❒ other: .....

10 Please give details of your vehicle:

Type of vehicle: car ❒ motor bike ❒ moped ❒

van ❒ lorry ❒ bus ❒

bicycle ❒ other: .....

Make of vehicle: .....

11 Please give details of the **OTHER** vehicle involved: .....

.....

.....

12 Were there any other passengers in your car? Yes ❒ No ❒ (Go to 13)

If yes, where were they sitting? .....

.....

13 Did your seat have a seat belt? Yes ❒ No ❒

If yes, were you wearing it at the time of the accident? Yes ❒ No ❒

14 Did your seat have a head rest in place? Yes ❒ No ❒

15 Did you have any warning that the accident might happen? Yes ❒ No ❒

If yes, how many seconds warning did you have? .....

Did you brace yourself / take any evasive actions to minimise your injuries? .....

.....

.....

INJURIES SUSTAINED

16 Please list **ALL** injuries / symptoms that you suffered as a result of this accident / incident. Please also confirm how long you suffered from these symptoms.

(i) .....

(ii) .....

(iii) .....

(iv) .....

(v) .....

(vi) .....

(vii) .....

(viii).....

HOSPITAL TREATMENT AFTER INJURY

17 Did you attend hospital for treatment?

If yes, which one?.....

What X-rays did you have?.....

Did you have stitches, how many and where?.....

What drugs were you given? (*e.g. painkillers, antibiotics etc*).....

Were you given a neck collar? Yes ❒ No ❒

If yes, how long did you wear it for?.....

Were you given a sling? Yes ❒ No ❒

If yes, which arm? .....

Did you have a plaster put on? Yes ❒ No ❒

If yes, which part of your body was plastered and for how long? .....

What advice were you given?
(*eg head injury instructions, time off work, bed rest, use ice, elevation to reduce swelling etc*)

.....

.....

.....

Were you told to return to hospital or see your GP for follow up? .....

18 Were you admitted to hospital? Yes ❒ No ❒ (go to 19)

(i) How long were you admitted for (with dates if known)? .....

(ii) Which consultant was in charge of your care (if known)? .....

(iii)What treatment did you receive? .....

(iv)What follow up did you have as an out patient afterwards? .....

(v) Are you still receiving hospital treatment? Yes ❒ No ❒

GP TREATMENT AFTER INJURY

19 Did you see your GP after the injury? Yes ❒ No ❒ (Go to 20)

How many times did you see your GP for injuries sustained in this accident / incident?
(*Please mention approx dates of the visits)*

.....

Are you still receiving GP treatment? Yes ❒ No ❒

PAST MEDICAL HISTORY AND MEDICATION

20 Do you, or have you suffered in the past from any serious illnesses?
(*Include all illnesses requiring hospital attendance* (*out-patient or in-patient*) *with dates and severity)*

.....

.....

21 What regular medication are you on *(whether prescribed by your doctor or obtained directly from the chemist)*?

.....

CONSEQUENTIAL LOSS

22 How long were you off work? .....

Did your GP certify you off work because of the injury? Yes ❒ No ❒ (Go to 23)

If yes, how many certificates did you need? One ❒ Two ❒ Three ❒

23 When did you return to work: .....

Did you resume normal duties? No ❒ Yes ❒ (Go to 24)

If not, what were your duties and how long did you do these before returning to normal duties?

.....

.....

.....

24 Please list below all your hobbies:
(mention how often you participated in them before the injury and afterwards)

.....

.....

.....

25 List below any domestic problems affected by your injury:
(eg DIY, gardening, cooking, ironing, shopping, sex life)

.....

.....

.....

.....

.....

PREVIOUS INJURY / CLAIMS

26 Have you ever suffered a similar injury or made a similar claim? Yes ❒ No ❒ (go to 27)

If yes, please give details of the injury or claim:

.....

.....

.....

PHYSICAL BUILD

27 What is your height? .....

28 What is your weight? .....

STATEMENT OF TRUTH

"I believe that the facts stated in this document comprising 4 pages are true"

SIGNED: ..... DATED: .....

FULL NAME: .....
(of person completing the form,who must be over 16 years old)