COMPREHENSIVE ACCIDENT HISTORY

Patient File #: _____ **Today's Date:** _____ **Injury Date:** _____

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask the receptionist for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

PERSONAL INFORMATION

Patient Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Marital Status: _____

Gender: ☐ Male ☐ Female Home Phone: _____ Cell Phone: _____

Social Security Number: _____ Email Address: _____

Spouse's Name: _____ Name and Ages of Children: _____

Is your spouse a patient in our office? ☐ Yes ☐ No

Employment Status: ☐ Employed ☐ Unemployed ☐ Full Time ☐ Part Time ☐ Student ☐ Other _____

Business Name: _____ Occupation/Job Title: _____

Business Address: _____

Business Phone: _____ Type of Work: _____

Is it ok to contact you at work? ☐ Yes ☐ No

Emergency Contact Information

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship: _____ Home Phone: _____ Cell Phone: _____

Primary Care Physician: _____ Physician Phone: _____

Insurance Information

AUTO ACCIDENT INSURANCE INFORMATION: If you have not completed an application of benefits from you auto carrier, you must do so for charges to be covered.

Auto Insurance Carrier: _____

Auto Insurance Carrier Phone: _____ Ext: _____

Insurance Carrier Address: _____

Claim Adjuster's Name: _____ Claim Number: _____

WORKER'S COMPENSATION INFORMATION: An accident report must have been filed with your employer for charges to be covered and a workers' compensation form must also be completed. If our clinic is not part of your employer's worker's compensation panel, you may be required to go to a panel provider for and initial visit before requesting transfer of your case to this office. If you are unsure if we are part of your employer's panel, please ask a member of our staff for assistance.

Employer Name: _____ Occupation/Job Title: _____

Employer's Phone: _____ Ext: _____

Employer Address: _____

Human Resource Manager's Name: _____ Claim Number: _____

Patient Name: _____ **Patient File #:** _____

GENERAL INSURANCE INFORMATION: Who besides yourself is responsible for your bill? ☐ Worker's Comp

☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Other (Be Specific): _____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Insured Person's Name: _____ Group #: _____

Insured Person's Date of Birth: _____ Insured Person's Social Security #: _____

EMERGENCY CONTACT:

Emergency Contact Name: _____ Relationship to You: _____

Home phone: _____ Alt. phone: _____

PERSONAL INFORMATION:

Home phone: _____ Work phone: _____

Cell Phone: _____ E-mail address: _____

Patient's Employer: _____ ☐ Retired ☐ Unemployed ☐ Student

Employer's Address: _____ Occupation/Job Title: _____

Spouse's Name: _____

Spouses Social Security: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Name of Person Responsible for this account: _____ Relationship to Patient: _____

How many children do you have? _____ Ages of Children: _____

Allergies: _____ Have you ever had surgery or been hospitalized? ☐ Yes ☐ No

List Surgeries: _____

Past serious accidents/injuries/motor vehicle accidents with dates: _____

Current medications/vitamins you are taking: _____

Do you have, or have you ever had any of the following health problems? **(Check all that apply)**

☐ Headaches ☐ Achyness / General Pain ☐ High / Low Blood Pressure ☐ Auto Accidents ☐ Migraine ☐ Difficulty Concentrating
☐ Excessive Sweating ☐ Other Accidents/ Falls ☐ Neck Pain / Stiffness ☐ Memory Loss / Forgetful ☐ Stomach Problems
☐ Frequent Colds / Flus ☐ Work Injuries ☐ Numbness / Tingling Arm(s) ☐ Sports Injuries ☐ Shoulder Pain / Stiffness ☐ Nausea
☐ Elbow Pain / Stiffness ☐ Irritability ☐ Liver / Gall Bladder Problems ☐ Nervousness ☐ Ulcers ☐ Fainting
☐ Wrist / Hand Pain or Stiffness ☐ Kidney Problems ☐ Digestion Problems ☐ Mood Disorders ☐ Irritability ☐ Depression ☐ Diabetes
☐ Tension ☐ Diarrhea ☐ Stress ☐ Sinus Problems ☐ Emotional Disorders ☐ Poor Diet ☐ Allergies ☐ Anxiety ☐ Cancer
☐ Low Back Pain or Stiffness ☐ Mid Back Pain or Stiffness ☐ Upper Back Pain or Stiffness ☐ Knee Pain or Stiffness ☐ Incontinence
☐ Hip Pain or Stiffness ☐ Ear Infections ☐ Ear Infections ☐ Impotence ☐ Hearing / Ear Problems ☐ Constipation
☐ Ankle/Foot Pain or Stiffness ☐ Trouble Walking ☐ Pain w/ coughing ☐ Pain shooting down leg(s) ☐ Bladder Problems
☐ Menstrual Problems (PMS) ☐ Asthma ☐ Bed Wetting ☐ Pain at stools ☐ Prostate Problems ☐ Thyroid Problems
☐ Restricts Exercise ☐ Dizziness ☐ Restricts Daily Activity ☐ Painful Joints ☐ Sore Muscles ☐ Dizziness ☐ Pain w/ sneezing
☐ Tiredness / Fatigue ☐ Circulation Problems ☐ Heart Problems ☐ Fractured Bones ☐ Trouble Breathing
☐ Other Problems not listed: _____

_____ _____

PATIENT'S SIGNATURE DATE

Patient Name: _____ **Patient File #:** _____

AUTO ACCIDENT HISTORY

WELCOME: The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will refer you to the appropriate healthcare provider. If you are a candidate for chiropractic care; a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete questions to the best of your ability. Be as descriptive as possible and check all descriptors that apply. If you have questions, please ask a staff member for assistance or clarification. Please inform the doctor if there are circumstances surrounding your accident that are not covered here and that you feel would be helpful.

Name _____ Today's Date _____

HISTORY OF OCCURRENCE Date of Accident _____

1. I was the/a:
    a. What was your point of impact?
    b. Did you feel pain immediately following the accident?
        If you answered no how long after the accident was it before the pain started? _____ Days
    c. Where did you go after the accident?
    d. Did you receive any of the following:
    e. How did you get there?
    f. List any doctors you've seen prior to this first visit to our office, their specialty, and any treatments received:

_____ __ _____

2. Patient Vehicle Type

3. Second Vehicle Type

4. Third Vehicle Type:

5. Road Conditions:

6. Road Type:

7. Were you aware the accident was going to occur?

8. Were you wearing a seatbelt?

9. Did your airbag deploy?

10. Does your car have a headrest?

11. What position was the headrest in?

12. Head Position:

13. Were you pushing the brake (stopping) either during or before impact?

14. Was your car moving before impact?
    If yes, how fast? (mph)

15. Was the driver of the second vehicle braking (stopping)?

16. Was the second vehicle moving before impact?
    If yes, how fast? (mph)

Patient Name: _____ **Patient File #:** _____

17. Was the driver of the third vehicle braking (stopping)?

18. Was the third vehicle moving before impact?

If yes, how fast? (mph.)

COLLISION DETAILS *(Describe how the cars collided. My vehicle was…)*

19. First Impact:

(My car was hit in the…)

20. Second Impact:

(My car was hit in the…)

COLLISION RESULTS *("During the accident my…")*

21. Body was thrown:

22. Head Hit:

23. Chest Hit:

24. Shoulders Hit:

25. Knees Hit:

26. Hips Hit:

If other area then describe:_____

VEHICLE DAMAGE

27. First Vehicle:

28. Second Vehicle:

29. Third Vehicle:

PERSONAL INJURY

30. Were you hospitalized? *(If yes, please answer the questions in the paragraph below.)*

When were you hospitalized? Date _____

How were you transported to the hospital?

What did the hospital recommend?

Did you have any x-rays, CT Scans or MRI's taken? If yes, what areas? _____

31. List all of your symptoms/complaints/conditions here:

32. Describe the quality of your symptoms:

33. How would you describe your current symptoms:

Patient Name: _____ **Patient File #:** _____

On a scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your condition or pain has:

34. **on your daily functioning when you are at rest**?

35. **on your daily functioning when you are active**?

36. When did this condition originally begin? _____

37. Is your condition currently.. ?

38. If you condition has worsened or is worsening, when did the increased symptoms start? _____

39. When was the last time you experienced these symptoms? _____

40. Is your condition is worse in the:
    and is it mostly:

41. Is your condition better in:

42. Is your condition worse in:

43. Check any of the following signs or symptoms that are associated with your current condition:

    Headaches (Describe your headaches in detail): _____

    (Describe the location and type of sensation): _____

    Weakness (Describe the location): _____

    Other not Listed (Describe):_____

44. Do your symptoms seem to be better with:

PAST HEALTH HISTORY

This section will identify key factors and indicators about your history that may impact or contribute to your current health condition. Please give us information on any below that apply to you.

45. Please list any medications or nutritional supplements that you are currently taking: _____

46. Please list any other doctors or providers that you have seen for this condition or for any conditions that you may be currently treating and the type of treatments provided: _____

47. Childhood Illnesses (Please list any illnesses that you have had as a child): _____

48. Adult Illnesses (Please list any illnesses that you have had as a child): _____

49. Surgeries (Please list all surgical procedures that have had in the past): _____

50. Injuries (Please list any significant injuries, falls, trauma, accidents that you have had in the past): _____

51. Immunizations (Please list any vaccinations that you have had): _____

52. Non Drug Allergies and how you react to those substances: _____

Patient Name: _____ **Patient File #:** _____

FAMILY HISTORY

This section will identify any possible genetic characteristics or risk factors that may impact or contribute to your current health condition.

53. Please describe your family history:

General Family:

Father: _____

Mother: _____

Paternal Grandfather _____

Paternal Grandmother _____

Maternal Grandfather _____

Maternal Grandmother _____

Son(s): _____

Daughter(s): _____

Brother(s): _____

Sister(s): _____

Additional: _____

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Patient Name: _____ **Patient File #:** _____

SOCIAL & WORK HISTORY

This section will identify key factors and indicators about your lifestyle that may impact or contribute to your current health condition. Please check as many as apply.

54. Please describe you alcohol use:

    How much alcohol do you regularly drink? _____

55. Please describe your average diet:

56. What is the highest education level you have attained? _____

57. Have you ever used illegal substances or IV drugs?

58. Please describe your tobacco use:

59. Please describe your condition's effect on your activities of daily living (ADL's):

    Caring for Infirm Family:

    Carrying Groceries:

    Change Position (Sit to Stand):

    Climbing Stairs:

    Daily Pet Care:

    Driving:

    Extended Computer Use:

    Household Chores:

    Lifting Children:

    Self Care–Bathing:

    Self Care–Dressing:

    Self Care–Shaving:

    Sexual Activities:

    Sleeping:

    Static Sitting:

    Static Standing:

    Walking:

    Yard Work:

Patient Name: _____ **Patient File #:** _____

60. Please list any recreational activities or hobbies and describe your condition's effect on those activities:

List: _____

List: _____

List: _____

List: _____

61. Please describe you current employment status:

62. How would you classify your job based on the following lifting limits?

63. How often do you lift at your job?

64. Lifting Postures:

65. How many hours per day do you do each of the following activities?

Sitting: _ _ Standing: ___ Walking: _ ___ Climbing: _ ___ Pushing: _____ __

Pulling: _ _ Kneeling: ___ Reaching: _ __ Twisting: _ __

66. If you lift at work, what type of lifting is most frequent?

67. Please describe your condition's effect on your job performance:

Is there any other information that you feel would be relevant to your current condition that was not covered? Please explain in the following section any information that you feel would be helpful to the doctor in reviewing your case.

_____

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Review of Systems

Today's Date: _____

Patient Name: _____ **Patient File #:** _____

INSTRUCTIONS: Below is a list of conditions that may seem unrelated to the purpose of your appointment. These conditions can affect your overall course of care. Please check all that apply.

Constitutional:
- ☐ Chills
- ☐ Daytime Drowsiness
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

Eyes/Vision:
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Itching
- ☐ Photophobia
- ☐ Tearing
- ☐ Wears Glasses or Contacts

Ears, Nose and Throat:
- ☐ Bleeding
- ☐ Dental Implants
- ☐ Dentures
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dizziness
- ☐ Ear Drainage
- ☐ Ear Infection(s)
- ☐ Ear Pain
- ☐ Fainting
- ☐ Headaches
- ☐ Head Injury (history of)
- ☐ Hearing Loss
- ☐ Hoarness
- ☐ Loss of Smell
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Rhinorrhea (runny nose)
- ☐ Sinus Infections
- ☐ Snoring
- ☐ Sore Throats
- ☐ Tinnitus (ringing in the ears)
- ☐ TMJ Disorder

Respiration:
- ☐ Asthma
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sputum Production
- ☐ Wheezing

Cardiovascular:
- ☐ Chest Pain
- ☐ Claudication (leg pain or achiness)
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Orthopnea (difficulty breathing while lying)
- ☐ Palpitations (irregular or forceful heart beat)
- ☐ Paroxysmal Nocturnal Dyspnea (shortness of breath at night)
- ☐ Swelling of Leg(s)
- ☐ Ulcers
- ☐ Varicose Veins

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice (yellowing of the skin)
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber (quality)
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

Female:
- ☐ Birth Control Therapy
- ☐ Breast Lumps/Pain
- ☐ Burning Urination
- ☐ Cramps
- ☐ Frequent Urination
- ☐ Hormone Therapy
- ☐ Irregular Menstration
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Disharge

Male:
- ☐ Burning Urination
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy or Dribbling
- ☐ Prostate Problems
- ☐ Urine Retention

Endocrine:
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth

Skin:
- ☐ Changes in Nail Texture
- ☐ Changes in Skin Color
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia (numbness, prickling, tingling)
- ☐ Rash
- ☐ History of Skin Disorders
- ☐ Skin Lesions or Ulcers
- ☐ Varicosities

Nervous System:
- ☐ Dizziness
- ☐ Facial Weakness
- ☐ Headaches
- ☐ Limb Weakness
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors
- ☐ Unsteadiness of Gait

Psychological:
- ☐ Anhedonia (inability to experience joy)
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsion
- ☐ Depression
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Mood Changes

Allergy:
- ☐ Anaphylaxis (history of)
- ☐ Food Intolerance
- ☐ Itching
- ☐ Nasal Congestion
- ☐ Sneezing

Hematology:
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruises Easily
- ☐ Fatigue
- ☐ Lymph Node Swelling

Patient Name: _____ **Patient File #:** _____

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School

Date _____ Date of Injury _____

☐Initial ☐Update ☐ Final

Please check all that apply to your EXERCISE & SPORTS Activity *because of the accident*

☐ My exercise was affected by this crash
☐ I go to the gym & work out in pain
☐ I no longer go to the gym to work out
☐ I run but in pain
☐ I no longer run
☐ I take walks & have pain while walking
☐ I no longer take walks
☐ I used to make income at sports
☐ I have lost sports income since crash
☐ I am an amateur athlete
☐ I am a professional athlete
☐ _____
☐ _____

☐ I have gained _____ pounds since the accident
☐ I had to quit my _____ team after the accident
☐ I had to quit my _____ team after the accident
☐ I had to quit my _____ team after the accident
☐ I had to quit my _____ team after the accident
☐ I don't enjoy the sport of _____ __ anymore
☐ I didn't enjoy the sport of _____ for ____ weeks
☐ I don't enjoy the sport of _____ anymore
☐ I didn't enjoy the sport of _____ for ____ weeks
☐ I don't enjoy the sport of _____ anymore
☐ I didn't enjoy the sport of _____ for ____ weeks
☐ I don't enjoy the sport of _____ anymore
☐ I didn't enjoy the sport of _____ for ____ weeks

Please check all that apply to your HOBBY Activities *because of the accident*

☐ My hobbies were affected by accident
☐ Hobby #1 _____
☐ I can't do hobby #1 anymore
☐ I do hobby #1 but in pain
☐ I have lost money from not doing #1
☐ I didn't do hobby #1 for _____ weeks
☐ Hobby #2 _____
☐ I can't do hobby #2 anymore
☐ I do hobby #2 but in pain
☐ I have lost money from not doing #2
☐ I didn't do hobby #2 for _____ weeks

☐ Hobby #3 _____
☐ I can't do hobby #3 anymore
☐ I do hobby #3 but in pain
☐ I have lost money from not doing #3
☐ I didn't do hobby #3 for _____ weeks
☐ Hobby #4 _____
☐ I can't do hobby #4 anymore
☐ I do hobby #4 but in pain
☐ I have lost money from not doing #4
☐ I didn't do hobby #4 for _____ weeks
☐ _____

Please check all that apply to your TRAVEL Activities *because of the accident*

☐ Business travel was affected by crash
☐ Pleasure travel was affected by crash
☐ I hurt driving in my own car
☐ I am in too much pain to drive
☐ I hurt when a passenger in a car
☐ I am in too much pain to sit in a car
☐ I have anxiety when I'm in a car
☐ I hurt when I'm on an airplane
☐ I am in too much pain to travel by plane

☐ Travel Plan #1 _____
☐ I did not go on travel plan #1
☐ I went, but did not enjoy #1 as much
☐ I went and the accident had no effect on #1
☐ Travel Plan #2 _____
☐ I did not go on travel plan #2
☐ I went, but did not enjoy #2 as much
☐ I went and the accident had no effect on #2
☐ I missed time with my family/friends b/c can't travel

Patient Name: _____ **Patient File #:** _____

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)

Date _____ Date of Injury _____

☐ Initial ☐ Update ☐ Final

Please check all the DAILY LIVING Activities that cause you pain *because of the accident*

☐ Dressing
☐ Putting on pants
☐ Putting on shoes
☐ Tying my shoes
☐ Putting on shirt
☐ Combing my hair
☐ Drying my hair
☐ Washing my hair
☐ Taking a shower
☐ Taking a bath
☐ Leaning Forward
☐ Laying in bed
☐ Sitting in my favorite chair
☐ Sleeping
☐ Going out with my friends
☐ Sitting in a restaurant
☐ Shopping
☐ Driving to/from work
☐ Sitting in Church
☐ Playing with my children
☐ Caring for my children
☐ Bending at the waist
☐ Sitting in a movie theater
☐ Exercise
☐ Eating
☐ Stooping
☐ Squatting
☐ Kneeling
☐ Brushing my teeth
☐ Riding in a car
☐ Opening a jar
☐ Lifting a pan when cooking
☐ Closing the trunk on my car
☐ Opening the garage door
☐ Using my home computer
☐ Climbing stairs
☐ Going down stairs
☐ Sexual activity
☐ Turning my head to left or right
☐ Holding my head up all day
☐ Watching TV
☐ I have pain sitting & doing nothing
☐ Talking on the phone
☐ Reading
☐ Writing
☐ Opening doors
☐ Drying with a towel after a bath or shower
☐ Life has become a chore just to do normal things
☐ It is depressing to live like this
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Please check all that apply to your SCHOOL & EDUCATION Activities *because of the accident*

☐ School was affected by the accident
☐ I am a student at _____
☐ I am in the _____ year/grade
☐ I was ☐ full time ☐ part time
☐ I am now ☐ full time ☐ part time
☐ I had to take fewer classes b/c of crash
☐ I missed _____ days of school
☐ I had to drop out of school b/c of crash
☐ My grades are lower since the crash
☐ I have pain carrying my school books
☐ I hurt sitting in class more than _____ minutes
☐ My neck hurts when I look down to read
☐ I don't learn as quickly as before the crash
☐ I don't learn thing s as well as before the crash
☐ I have difficulty concentrating in class
☐ It takes much longer to study/do my homework
☐ _____
☐ _____

Signature of Patient _____ Date _____

Patient Name: _____ **Patient File #:** _____

Duties Performed Under Duress at Work and Home

Date _____ Date of Injury _____

☐ Initial ☐ Update ☐ Final

Please check all that apply to your WORK because of the accident

☐ I go to work but work in pain
☐ I limit my work activities
☐ Bending at work hurts
☐ Stooping at work hurts
☐ Sitting at work hurts
☐ Using the Computer at work hurts
☐ Pushing at work hurts
☐ Pulling at work hurts
☐ Kneeling at work hurts
☐ I have lost status in my company
☐ I have lost job security
☐ I didn't get a promotion
☐ I don't enjoy work as much as before
☐ I doze off at work
☐ I take unpaid time off work to go to Dr.
☐ I daydream at work more than before
☐ I feel tired at work
☐ _____
☐ _____

☐ I work in pain because I have bills to pay
☐ I can't take time off because I would lose my job
☐ I keep working so I don't lose stat us at company
☐ My business would fail if I took time off
☐ I believe in working even when I'm in pain
☐ I feel obligated to work even though I'm in pain
☐ My business would lose money if I took time off
☐ My work is not as good as it was before accident
☐ My boss reprimanded me for poor performance
☐ I got a different job within the same company
☐ I got a different job in another company
☐ I make less money than before the accident
☐ I cannot do the same work/job as before accident
☐ I can't concentrate as well at work
☐ I take paid time off to go to Dr.
☐ I make mistakes at work I didn't used to
☐ I hide my poor work performance from my boss
☐ _____
☐ _____

☐ My house is not as clean now
☐ My yard is not as neat now
☐ My garden is not as productive now
☐ I do yard work, but do it in pain
☐ I cannot do my normal yard work
☐ I do house work, but do it in pain
☐ I cannot do my normal house work
☐ Doing laundry hurts me
☐ I cannot do laundry now
☐ Washing dishes hurts me
☐ I cannot wash dishes now
☐ Vacuuming hurts me
☐ I cannot vacuum now
☐ Cooking hurts me
☐ I cannot cook now
☐ Washing the car hurts me
☐ I cannot wash my car
☐ _____
☐ _____

☐ I cannot take time off because I care for children
☐ I have _____ children ages _____
☐ I had to hire a paid housekeeper
☐ I asked someone for unpaid housekeeping help
☐ I had to hire a paid gardener
☐ I asked someone for unpaid yard work help
☐ Mowing the lawn hurts me
☐ I cannot mow the lawn
☐ Taking out the trash hurts me
☐ I cannot take out the trash
☐ I do not enjoy my gardening/yardwork like I used to
☐ I do not enjoy my housework like I used to
☐ Gardening hurts me
☐ I cannot do my gardening at all since the accident
☐ Others living with me do my share of the work now
☐ Others living with me do my share of the yard work
☐ Others living with me do my share of the gardening
☐ _____
☐ _____

Signature _____ Date _____