

Pre-Medical Questionnaire - It is important that you complete this form before your medical.

1. About You

Full Name:					
Address:					
Date of Birth:		Left Handed	<input type="checkbox"/>	Right Handed	<input type="checkbox"/>

2. Past Medical History - Have you had any previous accidents, injuries or health problems? Please list them here, including when they occurred, what treatment was needed, and whether they still affect you now. If you need more space, please continue on "**Other Information & Comments**" page.

Previous Accidents				
a) Have You Been Involved in Any Previous Accidents?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
b) Date of previous accident:				
c) Any other accidents?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
e) Did you make a full recovery?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
f) How long did your recovery take?				
Physical Health				
g) Are you normally in good health?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
h) Have you had any serious illnesses?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
i) Have you previously had neck, back or shoulder problems?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Mental Health				
j) Have you previously suffered with anxiety or depression?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Current Medication				
k) What treatments/medication do you currently receive?				

3. The Accident - This section is for people who were in a vehicle at the time of the accident. If that doesn't apply to you, please describe your accident on the "**Other Information & Comments**" page.

a) Date of Accident		b) Approx. Time of Accident	
c) What type of vehicle were you in?			
d) Was there an airbag?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
e) Did it deploy?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
f) Were you wearing a seatbelt?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
g) Was there a headrest fitted?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
h) Your Position? Driver, front or rear seat passenger?			
At the time of the accident was your car:			
i) Moving, stationary or turning?			
j) At a Roundabout, set of traffic lights, at a junction?			
k) Were you expecting to be hit?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
l) Did you brace for impact?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
m) Did you need any help to get out of the Vehicle?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
n) How badly damaged was the vehicle following the accident?			
o) Thrown at Impact: How were you thrown at impact?			

4. Initial Injuries & Symptoms - Please describe the injuries or symptoms you noticed at the time of the accident. Include both physical & any psychological symptoms you experienced. If you need more space, please continue on "**Other Information and Comments**" page. An example has been completed to guide you.

a) Injury or Symptom: Briefly describe what you felt.	b) Initial Severity: How bad was it at first? Mild, Moderate, Severe	c) Current Status: How bad is it now? Mild, Moderate, Severe	d) If it has resolved: how long after the accident did it resolve?
<i>Example: Neck Pain</i>	<i>Moderate</i>	<i>Cleared up</i>	<i>After 3 months.</i>

5. Later Symptoms - Please describe any symptoms that came on some time after the accident.

a) Symptom: Briefly describe what you felt.	b) Delay: How long after the accident did it start?	c) Initial Severity: How bad was it at first? Mild, Moderate, Severe	d) Current Status: How bad is it now? Mild, Moderate, Severe.	e) If it has resolved: how long did it take to resolve?
<i>Example: Back Pain</i>	<i>3 days</i>	<i>Moderate</i>	<i>Still stiff and sore.</i>	<i>3 weeks</i>

6. Initial Treatment - What treatment did you receive on the day of the accident?

Treatment at the Scene:				
a) Did you need any Treatment?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
b) Who Treated you? E.g. paramedic, passer-by. Etc.				
c) What was the treatment? E.g. dressings, pain Killers. Etc.				
Travel from the Scene:				
d) Where did you go next? E.g. home, work, casualty. Etc.				
e) How did you get there? E.g. drove, got a lift, ambulance. Etc				

Other Treatment on the day of the accident:				
f) Did you receive any?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
g) Where did you have it? E.g. Casualty, GP, Home, Work. Etc				
h) What was the treatment? E.g. dressings/pain killers. Etc.				
i) Did you have any tests? E.g. x-rays, visual, hearing. Etc.				
j) What were the results? E.g. normal /fracture. Etc.				

7. Later Treatment - What other treatment have you received since the accident?

a) Treatment: What treatment have you had? How many visits or sessions? E.g. GP, physiotherapy	b) Timing: How long after the accident did you start the treatment?	c) Outcome: How successful has it been? E.g. physio; improved neck pain. E.g. GP gave sick note and painkillers.
<i>Example: Attended GP 3 times</i>	<i>3 days, 2 weeks, and 4 weeks</i>	<i>Got sick note, painkillers and physio referral.</i>

8. Effect on Work - How has the accident affected your work? If you have more than one job, please give details on the "**Other Information and Comments**" page.

a) What is your job? E.g. taxi driver	
b) Normal hours per week? E.g. 40 hours	
c) How much time off? E.g. None, 2 weeks, still off?	
d) Light Duties? For how long? Duties still light?	
e) Reduced Hours? For how long? Hours still reduced?	
f) Lost Job? Why? What happened?	
g) Changed Job? Why? What do you do now?	

9. Effect on Travel - Have you had any problems as a driver or a passenger?

As a Driver:	
a) Any pain or discomfort?	
b) How severe has it been?	
c) How long has it lasted?	
d) Any anxiety?	
e) How severe has it been?	
f) How long has it lasted?	

As a Passenger:	
g) Any pain or discomfort?	
h) How severe has it been?	
i) How long has it lasted?	
j) Any anxiety?	
K) How severe has it been?	
l) How long has it lasted?	

10. Home Situation - Who lives with you at home?

a) Adults: e.g. partner, parents...	
b) Children:	
c) How many?	
d) What are their ages?	

11. Effect on Home Life - How has the accident affected your home life? If there have been problems, please list them below.

a) Problem: Briefly describe the problem. E.g. housework, shopping, sport. E.g. missed out on holiday (include destination) or special event.	b) Current Status: How bad was it to start with? How bad is it now? If it has resolved, how long did it take to resolve?
<i>Example: Could not do shopping because of shoulder pain. Husband had to carry the bags.</i>	<i>It settled after 3 weeks, but I still have problems with heavy items.</i>

12. Other Information or Comments - Please use this space to add any other information or comments you wish:

13. Final Declaration - Thank you very much for completing this questionnaire. The information will be used as part of the medical report that the doctor writes about you, so it is important that it is as detailed & accurate as possible. Please sign & date the declaration:

I confirm that the information given in this questionnaire is a true & accurate description of the circumstances & injuries of my accident.

Signed:

Date: