LIFE IMPACT SURVEY

Your Name:____Date:______/_____/__________

QUALITY OF LIFE IMPACT

1. Injuries

Describe in detail all injuries you received in this accident.

BODY PART / AREA	INJURY	CURRENT SYMPTOMS

2. Pain

Please describe in detail any pain which you have experienced because of the accident, and the current frequency of the pain:

LOCATION OF PAIN	DESCRIPTION OF PAIN	CURRENT FREQUENCY

3. **Physical Limitations**

What effect have your injuries had on your physical ability to do the following:

ACTIVITY	EFFECT OF INJURIES
Walking	
Sitting	
Climbing Stairs	
Lifting	
Standing	
Driving	
Intimacy	
Participating in Sports /Which Sports?	
Gardening	
Woodworking/Crafts	
Sewing/ Embroidery/Needlework	
Playing a Musical Instrument Which instrument?	
Playing with Children	
Cooking	
Laundry	
Cleaning	
Ironing	
Washing the car	
Yard Work	
Other	
Other	

4. Physical Leisure Activities Affected

Before this accident, what sort of specific leisure activities did you regularly enjoy doing after work or outside the home? Please indicate specific activity, such as bowling, skiing, gardening, hunting, etc., and how often before the accident you would normally take part in such activities and how often you do so now.

LEISURE ACTIVITY	HOW OFTEN **BEFORE** ACCIDENT	HOW OFTEN **AFTER** ACCIDENT

5. Social Activities

What social activities have you had to reduce or abandon?

SOCIAL ACTIVITY	EFFECTS
Entertaining Guests	
Charitable/Social Organizations	
Concerts/Plays	
Going Out With Friends	
Club Activities	
Dancing	
Going to Museums	
Other ______________________	
Other ______________________	
Other ______________________	

Please describe how you feel at the present time and any changes in your daily routine from your injury:

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6. <u>Home Confinement</u>

Were you ever confined to bed at home as a result of this accident: ☐ Yes / ☐ No If yes, please give the dates when you were confined in bed and the reason:

DATES CONFINED IN BED AT HOME	REASON
____/____/________through____/____/________	
____/____/________through____/____/________	

Were you at any time confined to your home after the accident: ☐ Yes / ☐ No If yes, please provide the dates and the reasons for such confinement:

DATES CONFINED AT HOME	REASON
____/____/________through____/____/________	
____/____/________through____/____/________	

7. <u>School/Work Loss</u>

If you were attending school at the time of the accident and lost time from school, please provide the dates you lost time from school due to your accident injuries.

DATES YOU LOST FROM SCHOOL	REASON
____/____/________through____/____/________	
____/____/________through____/____/________	

8. **Other Difficulties**

Are you still able to help people when they need help? For example, can you still babysit a friend/relative's children or your grandchildren? Can you still visit people from your church temple or mosque who were sick and unable to attend services? Take a few minutes to think about this question and then write a little bit about these kind of changes.

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Have you experienced any other difficulties of any kind because of this accident which have not been covered above: If yes, please describe in detail:

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9. **Quality of Life Witnesses**

Please provide the name of anyone (include members of your family, neighbors, friends) who may know what effect your accident injuries have had on your hobbies, activities or physical condition in general:

NAME	RELATIONSHIP	PHONE #	WHAT THEY KNOW

MEDICAL TREATMENT

10. Hospital Care

As a result of your injuries, were you treated in a hospital: ☐ Yes / ☐ No If yes, please provide the following:

HOSPITAL	ER ONLY?	# OF DAYS ADMITTED	INJURIES TREATED
	☐		
	☐		

11. Medical/Dental or Chiropractic Care

Which doctors, dentists, osteopaths, chiropractors or physical therapists have you seen as a result of this accident? Please list in the order you saw them.

DOCTOR	INJURY TREATED	LENGTH OF TREATMENT	DATE LAST TREATED

DENTIST	INJURY TREATED	LENGTH OF TREATMENT	DATE LAST TREATED

CHIROPRACTOR	INJURY TREATED	LENGTH OF TREATMENT	DATE LAST TREATED

PHYSICAL THERAPIST	INJURY TREATED	LENGTH OF TREATMENT	DATE LAST TREATED

12. Medications Taken

As a result of the accident, have you taken any aspirin, drugs, medications or any other prescriptions on the advice of a doctor: ☐ Yes / ☐ No If yes, please provide the following information:

PRESCRIPTION	PRESCRIBING DOCTOR	PHARMACY	NUMBER OF FILLS	LAST DATE TAKEN

Do you take over-the-counter medications for your accident injuries?

OTC MEDICATION	FREQUENCY	LAST DATE TAKEN

13. Other Care

Have you had to have any home nurses or aides, friends, relatives or others act as nurses in connection with this accident: ☐ Yes / ☐ No If yes, please provide the following information:

CARE PROVIDER	SERVICE(S) PROVIDED
Home Nurse / Aide	
Friend	
Relative	
Other	

14. **Household Help**

Have you had to hire or obtain anyone around the house, as a result of this accident, to help out? This would include babysitters, people to do washing, ironing, etc.: ☐ Yes / ☐ No If yes, please provide the following:

PROVIDER	SERVICE GIVEN	DATE OF LAST SERVICE
Babysitter		
Housekeeper		
Friend		
Other		

Have you used any of the following in connection with treatment?

☐ Back Brace ☐ Neck Brace ☐ Crutches /Cane ☐ Wheelchair ☐ Traction ☐ Splints ☐ Physiotherapy
☐ Prosthetics ☐ Mobility Scooter ☐ Other____

UNPAID MEDICAL COSTS

15. **Unpaid Expenses**

We would like to confirm all the bills that you have received because of this accident and any amounts that you have paid out-of-pocket and remain unpaid or medical bills that remain unpaid.

DOCTORS	AMOUNTS YOU PAID OR REMAIN UNPAID

HOSPITALS	AMOUNTS YOU PAID OR REMAIN UNPAID

DENTIST	AMOUNTS YOU PAID OR REMAIN UNPAID

MEDICATIONS	AMOUNTS YOU PAID OR REMAIN UNPAID

CHIROPRACTORS	AMOUNTS YOU PAID OR REMAIN UNPAID

X-RAYS / MRI'S	AMOUNTS YOU PAID OR REMAIN UNPAID

AMBULANCE	AMOUNTS YOU PAID OR REMAIN UNPAID

HOME NURSES/AIDES	AMOUNTS YOU PAID OR REMAIN UNPAID

CRUTCHES, BRACES, TRACTION, ETC.	AMOUNTS YOU PAID OR REMAIN UNPAID

WAGE IMPACT

16. Wage Loss

Were you employed at the time of your accident? ☐ Yes / ☐ No If yes, please provide the following:

EMPLOYER	JOB TITLE	WEEKLY PAY AT TIME WORK MISSED	HOURS WORKED EACH WEEK
		$	
		$	

Did you have benefits provided by your employer? ☐ Yes / ☐ No If yes, please provide the following:

EMPLOYMENT BENEFITS	AMOUNT YOU PAID	AMOUNT EMPLOYER PAID
401k		
Medical Insurance		
Dental Insurance		
Life Insurance		
Disability Insurance		
Other_____________________________		

Did you miss time from work as a result of your injury? ☐ Yes / ☐ No If yes, please provide the following:

EMPLOYER	PAY RATE	DATES MISSED FROM WORK	WAGES LOST
		____/____/________ - ____/____/________	$
		____/____/________ - ____/____/________	$
		____/____/________ - ____/____/________	$
		____/____/________ - ____/____/________	$

If you have returned to the job you had before your accident, have the duties of your work changed since the date of the accident: ☐ Yes / ☐ No If yes, please explain fully:

____

____

____

____

Have you changed employment because of your injuries: ☐ Yes / ☐ No If yes, please explain fully:

____

____

____

____

If you have returned to work or continued working are there job duties or activities that you have difficulty performing due to your accident injuries? ☐ Yes / ☐ No If yes, please explain fully:

____

____

____

____

PROPERTY DAMAGES

17. Property Damage

Describe accident damage to your vehicle and any personal property.

PROPERTY ITEM	TYPE OF DAMAGE	COST OF REPAIR	TOTAL LOSS VALUE (IF NOT REPAIRED)

HELPFUL BACKGROUND INFO

18. Military Service

BRANCH	DATES OF SERVICE	COMBAT VETERAN	TYPE OF DISCHARGE
	____/____/________ - ____/____/________	☐ Yes / ☐ No	

19. Memberships in Community Organizations and Clubs

CLUB/ORGANIZATION	POSITIONS HELD	CURRENT MEMBERSHIP STATUS

ANYTHING NEW

In completing this interview outline, have you thought of anything else that may have some bearing either positive or negative on your case: ☐ Yes / ☐ No If yes, please indicate:

POSTIVE FACTORS	NEGATIVE FACTORS