Medico-Legal Evaluations, P.A.
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General Injury Questionnaire

Fill out only the form(s) for the body area(s) that were injured. Type into this form on a computer or phone, save it and email it to **info@mlenj.com** before your appointment, or print it and bring it. Please also bring any X-ray, MRI or CT films or discs.

Full name | **Date of birth** | **Today's date**

Your injury

When did the injury happen?

How did the injury happen?

Which part(s) of your body were injured? (check all that apply)

☐ Head / brain (concussion) ☐ Face ☐ Eyes ☐ Teeth / jaw ☐ Chest / ribs ☐ Breast
☐ Stomach / abdomen (hernia) ☐ Groin ☐ Skin (cuts, scars, burns) Other:

Do you have scars from this injury? ☐ Yes ☐ No If yes, where?

Before and after this injury

Before this injury, did you have any of these? (check all that apply)

☐ An injury to the same body part ☐ Pain or problems there ☐ Treatment there ☐ None of these

If you checked any, when and what happened (for example, another accident)?

Any other accidents or injuries since this injury? ☐ Yes ☐ No If yes, what happened?

Treatment and work

Which treatments have you had for this injury? (check all that apply)

☐ Emergency room ☐ Stitches ☐ Surgery ☐ Physical therapy ☐ Seen by a specialist
Other:

Work status: (check one)

☐ Full duty ☐ Light or restricted duty ☐ Not working because of this injury ☐ Retired ☐ Not working, other reason

Your job (or last job):

Pain

Do you have pain right now? ☐ Yes ☐ No

Pain right now

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

0 = No pain 10 = Worst pain imaginable

Pain at its worst in the last week

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

0 = No pain 10 = Worst pain imaginable

Where is the pain?

For head injuries only: do you have any of these? (check all that apply)

☐ Headaches ☐ Dizziness ☐ Memory problems ☐ Trouble concentrating ☐ Blurry vision ☐ Ringing in ears
☐ Sensitivity to light or noise

What other problems do you have now because of this injury?

Medications you take for pain or symptoms:

Activities

Which of these activities are harder for you **because of the injury or injuries described on this form?** For each activity, **check only one box**. Leave the row blank if the injury does not affect that activity.

Activity	I can't do it anymore	I can do it, but less than before	I can do it normally, but feel pain
Lifting and movement			
Lifting	○	○	○
Carrying objects	○	○	○
Bending or twisting	○	○	○
Taking a deep breath or coughing	○	○	○
Thinking, vision and hearing			
Reading or concentrating	○	○	○
Remembering things	○	○	○
Using a computer or phone	○	○	○
Being around bright light or noise	○	○	○
Household tasks			
Household chores	○	○	○
Taking care of children	○	○	○
Exercise and recreation			
Exercising or sports	○	○	○
Social activities	○	○	○
Daily activities			
Driving	○	○	○
Eating or chewing	○	○	○
Getting dressed	○	○	○
Sleeping	○	○	○
Sexual activity	○	○	○

Any other activities that are harder because of this injury: