PLEASE FILL IN BLOCK LETTERS

ACCIDENT & INJURIES QUESTIONNAIRE

Consultation Type: **Remote / F2F** **Consulting Location:** _____

Video software used: **WhatsApp/FaceTime/Skype/Zoom/GRIP/Other** _____

S

Date of Examination: _____/_____/_____

Proof of Identity: ☐ No ID provided ☐ I provide consent that my photo should be taken to publish on the report. Clients initials: _____

☐ Passport (Number) _____ ☐ Photo Work ID (Employer Name) _____

☐ Photo Driving Licence (Number) _____ ☐ Birth certificate ☐ Other _____

Title : Mr / Master / Mrs / Miss / Ms **Are you?** ☐ Right handed ☐ Left handed ☐ Ambidextrous

Claimant Full Name: ***Approximate Weight*** : ***Approximate Height*** :

Address: ***Postcode:***

Date Of Birth: / / ***Date of Accident:*** / /

Accompanied by: ***Full name:*** ***Date of birth:*** / /

Relationship to the claimant. ***If interpreter, please provide company name:***

Any previous accident? (within the last 5 years) ☐ Yes ☐No

If yes, how long ago: _____ days / months / years

Injuries Sustained: _____

Recovered after: _____ days / months / years

Symptoms worsened in this accident? ☐Yes ☐No

Any subsequent accident? ☐ Yes ☐No

If yes, how long ago: _____ days / months / years

Injuries Sustained: _____

Recovered after: _____ days / months / years

Symptoms worsened in this accident? ☐Yes ☐No

Any previous musculoskeletal or Psychological problems? ☐ Yes ☐No

If yes, how long ago: _____ days / months / years

Injuries Sustained: _____

Recovered after: _____ days / months / years

Symptoms worsened in this accident? ☐Yes ☐No

Any treatment received related to your previous conditions? ☐ Yes ☐No

(please give details if treatment received : _____ ☐ tick if treatment still continuing)

Type Of Current Accident (Incidence) - Please select one:

☐ Road Traffic Accident ☐ Pedestrian ☐ Trips Or Fall ☐ Injury at Work ☐ Other _____

If road traffic accident, then please choose the options below: **(e.g. car, van, bus, 4x4, truck etc.)**

Vehicle, positioning and safety features: **Your Vehicle:** _____ **Third party Vehicle(s)** _____

Time of accident: ☐ morning ☐ afternoon ☐ evening

Your Position: ☐ driving ☐ front seat passenger ☐ back seat passenger ☐ child seat ☐ booster seat For child & booster seat (Front seat / Rear seat)

Location: ☐ Roundabout ☐ Main Road ☐ Minor Road ☐ Motorway ☐ Junction ☐ Car park ☐ Queue of traffic ☐ Traffic light

Vehicle movement: ☐ Stationary ☐ Moving ☐ Parked ☐ Approaching ☐ Waiting to turn left/right ☐ Slowed down to turn left/right

Wearing Seatbelts? ☐ Yes ☐ No (Exemption if any _____) **If riding bike**: ☐ Helmet worn ☐ Protective clothing

Airbag Fitted and deployed? ☐ Yes ☐ Fitted but not deployed ☐ Not fitted **Headrest fitted?** ☐ Yes ☐ No ☐ Don't know

Type of impact: ☐ Hit by ☐ You hit the other vehicle

Direction of impact? ☐ Front/Head-on ☐ Passenger's side ☐ Driver's side ☐ Rear

Speed of impact? ☐ High (motorway) ☐ Medium (city road) ☐ Low (late braking) ☐ Does not remember

Got out of vehicle unaided? ☐ Yes ☐ No (if no who helped you: (driver / fellow passenger / paramedics / police /_____)

Damage to vehicle? ☐ Minor ☐ Moderate ☐ Extensive ☐ Written off ☐ Beyond economical repair

Thrown impact: jolted? ☐ Backwards ☐ Forwards ☐ Sideways ☐ knock to the ground (if riding bike) ☐ Others _____

In case of any other kind of incident please describe the brief details in CAPITAL Letters:

Injuries Sustained Neck, shoulder, back, etc. Bruising, swelling etc. Shock, shakiness, Nightmares, flashbacks etc.	**When started** Immediate / Next day	**Severity of Pain:** At the time when it started **PLEASE CIRCLE**	**How are they Now?** Only Fill this box if INJURIES are **FULLY RESOLVED** before this appointment	if INJURIES are **NOT RESOLVED** than how are they now? **PLEASE CIRCLE**
		mild / moderate / severe / exceptionally severe	☐ **Resolved** _____ weeks / months	**mild / moderate / severe / exceptionally severe**
		mild / moderate / severe / exceptionally severe	☐ **Resolved** _____ weeks / months	**mild / moderate / severe / exceptionally severe**
		mild / moderate / severe / exceptionally severe	☐ **Resolved** _____ weeks / months	**mild / moderate / severe / exceptionally severe**
		mild / moderate / severe / exceptionally severe	☐ **Resolved** _____ weeks / months	**mild / moderate / severe / exceptionally severe**
		mild / moderate / severe / exceptionally severe	☐ **Resolved** _____ weeks / months	**mild / moderate / severe / exceptionally severe**
		mild / moderate / severe / exceptionally severe	☐ **Resolved** _____ weeks / months	**mild / moderate / severe / exceptionally severe**
Fear of Travel		**mild / moderate / severe / exceptionally severe**	☐ **Resolved** _____ weeks / months	**mild / moderate / severe / exceptionally severe**

For Doctor Use Only: If the claimant had described symtoms exceptionally severe due to exceptional circumstances.

Do you agree with the claimant? YES / NO

If you agree or disagree with the claimant, please explain why you agree or disagree?

For Doctor Use Only: List of the injuries which were on the clinic list but denied by the claimant:

Brief post accident & treatment details:

Were you attended at the scene by? ☐ Paramedics ☐ First- Aider ☐ Fireman ☐ Police ☐ Air ambulance ☐ None ☐ Other

Immediately after the accident where did you go to? __________________ How did you travel? ___________________

Attended **Hospital** **or** **Walk in**? ☐ Yes ☐ No after………………?days Name of Hospital __________________

Any treatment or advice you were given?

Attended **GP**? ☐ Yes ☐ No after………………?days ☐ Advice____________ ☐ Treatment___________

Any treatment or advice you were given?

Had X-ray / CT Scan? ☐ Yes ☐ No If yes which part of body: ____

MRI / ECG / Other: ______________________________ The outcome: ☐ normal ☐ fracture ☐ no bony injury

Were you given Neck collar? ☐ Yes ☐ No If yes, how long did you wear it for? ____________________________________

Were you given a sling? ☐ Yes ☐ No If yes, for which arm and for how long? ______________________

Did you have a plaster put on? ☐ Yes ☐ No If yes, which part of your body was plastered and for how long? ______________________

Had Physiotherapy ☐Yes ☐No If yes, how many sessions you have taken? ____ Number of sessions recommended? _____

Physiotherapy Continuing? ☐Yes ☐No When physiotherapy was started?____/____/____ Finished: _____/_____/_____

Awating Physiotherapy: ☐Yes ☐No Who arranged the physiotherapy? ☐GP ☐Solicitor ☐Other:___________

Have you taken any **Painkillers** for? ☐ Yes (for how long ___ days/weeks) Any other treatment? _________________________________

Work: (or student) Hours per week: _____ / full-time / part-time Time Off Work/ studies for: _____ day / weeks

OCCUPATION at time of Accident: _____ ☐ Still off work?

If yes, please advise when likely to return: _____

Please note, occupations like “Worker”, “Director”, “Engineer” or “Self employed” are quite wide ranging and not acceptable, please write descriptive occupation such as "Office Administrator", “Receptionist”, "Manual Farm Labourer", "Coach Driver", "Computer Engineer", "Mechanical Engineer", "Car Mechanic", “Nurse” etc.

☐ Have you done any light duties? how long _____ days / weeks

☐ Have you worked reduced hours?

How long _____ days / weeks. Reduced hours ____ per week

Did you change your profession due to this accident? ☐ Yes ☐ No (If yes, what is your present occupation? _____)

Who lives with you at home? ☐ Alone ☐ Spouse ☐ Partner ☐ Parents ☐ others _____

☐ Children (If living with children, how many children _____ and how old are they ___,___,___)

Did you miss ☐ **Not enjoy >>>** ☐ Holiday ☐ Sporting Activity ☐ Social events ☐ Wedding ☐ Party

Domestic activities affected	Severity (At the time of the accident)	Only fill this box if the activity is **FULLY RESOLVED**	If activity is **NOT RESOLVED** than how is it now?	**Any further comments**
Sleep	☐ **mild** ☐ **moderate** ☐ **severe**	☐ **Resolved** _____weeks / months	☐ **mild** ☐ **moderate** ☐ **severe**	
Personal Care	☐ **mild** ☐ **moderate** ☐ **severe**	☐ **Resolved** _____weeks / months	☐ **mild** ☐ **moderate** ☐ **severe**	
DIY	☐ **mild** ☐ **moderate** ☐ **severe**	☐ **Resolved** _____weeks / months	☐ **mild** ☐ **moderate** ☐ **severe**	
Lifting Items	☐ **mild** ☐ **moderate** ☐ **severe**	☐ **Resolved** _____weeks / months	☐ **mild** ☐ **moderate** ☐ **severe**	
Cooking	☐ **mild** ☐ **moderate** ☐ **severe**	☐ **Resolved** _____weeks / months	☐ **mild** ☐ **moderate** ☐ **severe**	
Shopping	☐ **mild** ☐ **moderate** ☐ **severe**	☐ **Resolved** _____weeks / months	☐ **mild** ☐ **moderate** ☐ **severe**	
	☐ **mild** ☐ **moderate** ☐ **severe**	☐ **Resolved** _____weeks / months	☐ **mild** ☐ **moderate** ☐ **severe**	

Sports affected Severity (At the time of the accident)		Only fill this box if the activity is **FULLY RESOLVED**	If activity is **NOT RESOLVED** than how is it now?	**Frequency of Participation (times done per week/day)**
Exercise	☐ **mild** ☐ **moderate** ☐ **severe**	☐ **Resolved** _____weeks / months	☐ **mild** ☐ **moderate** ☐ **severe**	
Walking	☐ **mild** ☐ **moderate** ☐ **severe**	☐ **Resolved** _____weeks / months	☐ **mild** ☐ **moderate** ☐ **severe**	
Swimming	☐ **mild** ☐ **moderate** ☐ **severe**	☐ **Resolved** _____weeks / months	☐ **mild** ☐ **moderate** ☐ **severe**	
Football	☐ **mild** ☐ **moderate** ☐ **severe**	☐ **Resolved** _____weeks / months	☐ **mild** ☐ **moderate** ☐ **severe**	
	☐ **mild** ☐ **moderate** ☐ **severe**	☐ **Resolved** _____weeks / months	☐ **mild** ☐ **moderate** ☐ **severe**	

Please use this space to give any additional information. Please ask for additional sheet if required.

Are you completing this form for yourself? ☐ Yes ☐ No 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 claimant? _____

I hereby declare that the above information is true to the best of my knowledge, and that I give consent to the transfer of this information into the GRIP report writing system and any other software system if required for the purpose of completing the medical report.

Full Name: _____ **Date of Birth:** _____/_____/_____ **Signature:** _____ **Date:** _____/_____/_____

(For Doctor Use Only)

TIME SPENT WITH CLIENT _____

Outcome
0 - fade with time
1 - no significant cosmetic disability
2 - mildly significant cosmetic disability
3 - moderately significant cosmetic disability
4 - severely significant cosmetic disability

Psychological -- All Normal / Not required – (Circle as appropriate, otherwise choose options from below)

The claimant appeared well adjusted. Yes / No
There were signs of any overt psychological or psychiatric illness. Yes / No

Inspection/Palpation - No bruising or swelling were seen (Circle as appropriate, otherwise define below)

Inspection	Numbers	Part of Body	Size / Dimension	Caused By Accident	Outcome	Any Surgical Treatment required	Any referral i.e. plastic surgeon etc
Scar				Yes / No		Yes / No	
Bruise / Swelling / Graze				Yes / No		Yes / No	

Neck

All Normal/Not Examined/Unlikely related to the Injuries

	% Restricted - 100% means Full ROM	Appeared Painful	Appeared Discomfort		Exist / Not Exist
Forward flexion:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	Rt trapezius muscle tenderness	Y / N
Extension:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	Lf trapezius muscle tenderness	Y / N
Rt rotation:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	bony tenderness	Y / N
Lt rotation:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	muscle spasm	Y / N
Rt lateral flexion:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	soft tissue tenderness.	Y / N
Lt lateral flexion:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N		

Neurological findings: _____

Back

All Normal/Not Examined/Unlikely related to the Injuries

Back movements:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	Rt paraspinal muscle tenderness	Y / N
Lt straight leg raising:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	Lt paraspinal muscle	Y / N
Rt straight leg raising:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	bony tenderness	Y / N
Thoracic back:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	muscle spasm	Y / N
Forward flexion:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	soft tissue tenderness.	Y / N
Extension:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N		
Rt rotation:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N		
Lt rotation:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N		
Rt lateral flexion:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N		
Lt lateral flexion:	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N		

Neurological findings: _____

Upper Limb

All Normal/Not Examined/Unlikely related to the Injuries

S - Swelling. D - Deformity. T - Tenderness

	% Restricted - 100% means Full ROM	Appeared Painful	Appeared Discomfort		% Restricted - 100% means Full ROM	Appeared Painful	Appeared Discomfort	
Shoulder	Right: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N		Left: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	
Hand Movements	Right: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	S / D / T	Left: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	S / D / T
Elbow Movements	Right: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	S / D / T	Left: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	S / D / T
Wrist Movements	Right: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	S / D / T	Left: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	S / D / T
Power / Pincer grip	Right: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N		Left: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	

Neurological findings: _____

Lower Limb

All Normal/Not Examined/Unlikely related to the Injuries

Hip movement	Right: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	S / D / T	Left: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	S / D / T
Knee movement	Right: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	S / D / T	Left: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	S / D / T
Ankle movement	Right: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	S / D / T	Left: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	S / D / T
Toe movement	Right: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	S / D / T	Left: 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	S / D / T
Stand on tiptoes	50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N		Squat and rise 50% / 60% / 70% / 80% / 90% / 100%	Y / N	Y / N	

Neurological findings: _____

Prognosis - Please tick ☐ if all Symptoms has been resolved

Symptom	Causation	Exacerbation of Pre existing	Treatment i.e. etc physiotherapy/continue current treatment/MRI Scan/Referral to Orthopaedic Surgeon / psychiatrist etc.	Session	Timeframe to resolve completely/pre-accidental stage in months from date of examination
		Yes / No			
		Yes / No			
		Yes / No			
		Yes / No			

Claimant's name, address and date of birth was matched with Photo ID: YES / NO

Causation 0 - whiplash injury 2 - bony injury 4 - seatbelt injury 5 – Direct trauma
1 - soft tissue injury 3 - psychological trauma 6 – Head injury

☐ Index accident is responsible for the injuries sustained.
☐ No long term deformity or problem due to this accident.

