DUTIES UNDER DURESS
Have you continued to do any of the following activities despite the pain caused by your accident?

WORK
Why have you continued to work?
☐ I would lose my job if I took time off.
☐ I couldn’t support my family otherwise.
☐ I don’t believe in taking time off even when I am injured or in pain.
☐ My business would fail if I did not work.
☐ I cannot take time off, because I care for my own children.
☐ Other: ______________________________

I have experienced the following changes in my ability to perform at work:
☐ Mobility/STability Problems
  ☐ Climbing
  ☐ Kneeling
  ☐ Lifting
  ☐ Walking for Long Periods
☐ Dexterity Problems
  ☐ Finger Movements
  ☐ Wrist Movements
  ☐ Problems with Fatigue
☐ Postural Difficulties
  ☐ Bending
  ☐ Sitting for Long Periods
  ☐ Standing for Long Periods
  ☐ Stooping
☐ Problems with Anxiety/Depression
☐ Problems with Vertigo or Spinning Sensations
  ☐ Dizziness
  ☐ Giddiness
  ☐ Sensation of Irregular Motion
  ☐ Sensation of Whirling Motion
☐ Problems with Tinnitus or Ringing in the Ears
☐ Problems with Reduced Concentration
  ☐ Can’t Concentrate
  ☐ Can’t Think Properly
  ☐ Making Mistakes
  ☐ Pain
Where?___________________________________

Duration of Symptoms
☐ I experienced problems doing my normal work activities for _____ weeks.
☐ My doctors have instructed me that my inability to perform my normal pre-accident work activities without pain is a permanent condition.
☐ My problems in performing my normal work activities is ongoing, but my doctors have not instructed me that the conditions is permanent.

HOUSEHOLD
I have experienced problems with the following activities outside my home:
☐ Painting the Outside of the House
☐ Landscaping
☐ Mowing the Grass
☐ Trimming the Bushes/Trees
☐ Washing Windows
☐ Gardening
☐ Taking Out the Trash
☐ Washing the Cars
☐ Maintaining the Cars
☐ Maintaining Yard Equipment
☐ Doing Other External House Work; Specify:____________________________________
___________________________________________________________________________

Duration of Symptoms
☐ I experienced problems doing my normal household activities for _____ weeks.
☐ My doctors have instructed me that my inability to perform my normal pre-accident household activities without pain is a permanent condition.
☐ My problems in performing my normal household activities is ongoing, but my doctors have not instructed me that the conditions is permanent.

**DOMESTIC DUTIES**

I have experienced pain while performing the following activities *inside* my home, but have done them anyway:
- ☐ Laundry
- ☐ Dishwashing
- ☐ Vacuuming
- ☐ Washing Windows
- ☐ Cleaning
- ☐ Preparing Meals

Due to my injuries, I have brought in the following assistance:
- ☐ Paid Housekeeper
- ☐ Unpaid Assistance
- ☐ None

My family status would best be described as:
- ☐ Single
- ☐ Single Parent at Home
- ☐ Spouse Only
- ☐ Spouse and Children at Home

I have the following number of children:
- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ ____

The number of my children in the following age category is:
- ☐ Number of children 0 to 5 years: _________
☐ Number of children 5-11 years: ___________
☐ Number of children older than 11: _________

Domestic Assistance
☐ I do receive domestic assistance
☐ I do not receive domestic assistance

**Duration of Symptoms**
☐ I have experienced problems doing my normal domestic activities for _____ weeks.

☐ My doctors have instructed me that my inability to perform my normal pre-accident domestic activities without pain is a permanent condition.

☐ My problems in performing my normal domestic activities is ongoing, but my doctors have not instructed me that the conditions is permanent.

**STUDIES/EDUCATIONAL DUTIES**

As a student I have experienced problems with one of the following activities since the collision:
☐ Carrying Books
☐ Sitting in Classes
☐ Looking Down to Read Textbooks
☐ Other: ______________________________

I have also experienced the following changes in my ability to perform at school as a result of injuries sustained in my accident:
☐ Mobility/Stability Problems
   ☐ Climbing
   ☐ Kneeling
   ☐ Lifting
   ☐ Walking for Long Periods
☐ Dexterity Problems
   ☐ Finger Movements
   ☐ Wrist Movements
☐ Problems with Fatigue
☐ Postural Difficulties
  ☐ Bending
  ☐ Sitting for Long Periods
  ☐ Standing for Long Periods
  ☐ Stooping
☐ Problems with Anxiety/Depression
☐ Problems with Vertigo or Spinning Sensations
  ☐ Dizziness
  ☐ Giddiness
  ☐ Sensation of Irregular Motion
  ☐ Sensation of Whirling Motion
☐ Problems with Tinnitus or Ringing in the Ears
☐ Problems with Reduced Concentration
  ☐ Can’t Concentrate
  ☐ Can’t Think Properly
  ☐ Making Mistakes
☐ Pain:
  Where? ________________________________

At the time of this collision, my education would best be described as:
  ☐ High School
  ☐ Apprenticeship Studies
  ☐ Technical College
  ☐ University
  ☐ Correspondence Course

My attendance before the collision is best described as:
  ☐ Full Time
  ☐ Part Time

Duration of Symptoms
☐ I have experienced problems doing my normal studies/educational activities for _____ weeks.
☐ My doctors have instructed me that my inability to perform my normal pre-accident studies/educational activities activities without pain is a permanent condition.

☐ My problems in performing my normal studies/educational activities activities is ongoing, but my doctors have not instructed me that the conditions is permanent.

________________________________________   ___________________
Print Name (Patient)                      Date

________________________________________
Patient Signature