Pre-consultation Medicolegal Questionnaire

Please complete the following questionnaire and hand to Mr. Hahnel during your consultation. Please remember to bring ID with you.
(where responses are available in bold, please circle most relevant answer)

Consultation Date ……………………… Venue for consultation …………………..

I confirm that I have answered the questions below truthfully and to the best of my knowledge. I understand that Mr. Hahnel will securely digitally store any records sent to him for a period of 6 years. He will securely share information only when necessary with his secretary, instructed solicitors or their agents, other medical expert witnesses involved in the case. After this time, all information will be securely deleted.

Signed………………………………………. Date ………………………

Background

Name:…………………………………………… Date of Birth: ……………………………

What was your job at the time of the accident? ..…………………………………………….

How long were you off work following your injuries? ………… **days / weeks / months**

What is your job now? ……………………...…………………………………………….

About your current job:

Does this usually involve: **Light** / **Medium** / **Heavy** / **No** manual labour

How long have you been doing this type of work? ……………………… **months** / **years**

How many days sickness did you usually take before your accident? …... per **month / year**

Are you **Left** or **Right** handed ?

Please list any medical problems you had before your accident / injury?

……………………………………………………………………………………………

……………………………………………………………………………………………

Accident / Incident

Date of accident ……………................. Time of accident (24 hour clock): ………………..

Describe how you became injured …………………………………………………………

…………………………………………………………………………………………………

…………………………………………………………………………………………………

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…………………………………………………………………………………………………

Where did it hurt immediately afterwards? ……………………………………………………

……………………………………………………..

…………………………………………………………………………………………..……

…………………………………………………………………………………………..……

…………………………………………………………………………………………..……

Did any other parts of your body hurt later? **Yes** / **No** If so, when?

Parts of body	Date / Time pain started
1)	
2)	
3)	

Have you ever had pain in these parts of the body before the accident? **Yes / No**

If so, when?

	Parts of body	Date pain started
1)		
2)		
3)		

For your accident, did you attend hospital? **Yes / No** By ambulance? **Yes / No**

If so, how soon after the accident did you attend?

Immediately / within …… hours / within …… days / within …… months

If you attended hospital, which hospital? ……………………………………………………

Did you see your own G.P.? **Yes / No** Doctors name..Dr……………………………..…

If you did see your GP , how soon after the accident did you attend?

Immediately / within …… hours / within …… days / within …… months

Did you see a physiotherapist.? **Yes / No** Physiotherapy centre name ………….………

If you did see a physiotherapist, how soon after the accident did you attend?

Immediately / within …… hours / within …… days / within …… months

What treatment were you given? ………………………………………………………..

Did your pain improve subsequently? …………………………………………………….

Are you? **Improving / Staying the same / Getting worse**

If your symptoms are not changing, when did they reach their present state? …………….

Have you ever made a personal injury claim in the past? **Yes / No**

Present State

Where precisely in your body do you get the pain? (use one box per site of pain)

1)

What is its severity out of 10 ? (place a cross at the relevant point on the scale below)

☺ 0 ———————————————— 10 ☹

(no pain) (Worst Pain Imaginable)

2)

What is its severity out of 10 ? (place a cross at the relevant point on the scale below)

☺ 0 ———————————————— 10 ☹

(no pain) (Worst Pain Imaginable)

3)

What is its severity out of 10 ? (place a cross at the relevant point on the scale below)

☺ 0 ———————————————— 10 ☹

(no pain) (Worst Pain Imaginable)

4)

What is its severity out of 10 ? (place a cross at the relevant point on the scale below)

☺ 0 ———————————————— 10 ☹

(no pain) (Worst Pain Imaginable)

What medication do you take daily for the pain? ………………………………………………...

……………………………………………………………………………………………...

And how often? ………………………………………………………………………………...

Have you received any other treatments ? e.g. physiotherapy / chriropractor / surgery /

occupation health ……………………………..…………………………………………………….

……….…………………………………………………………………………………………

……….…………………………………………………………………………………………

……………………………………………………………………………………….………

Have you had any investigations ? E.g. Xrays, Ultrasound, CT scan MRI scan

……………………………………………………………………………………………….

……….…………………………………………………………………………………………

Effect of injury on employment and recreation?

How long were you off work after the accident? …………….. **days / months** / **years**

If you have returned to work, in what ways are you restricted? ……………………………....

………………………………………………………………………………………………

………………………………………………………………………………………………

……………………………………………………………………………………….…..

Does the injury affect your earning capacity? **Yes** / **No**

If so, by how much? ……………. (percentage loss of normal take home pay)

How has the injury affected your relationships or mental health? ……………………………

………………………………………………………………………………………………

………………………………………………………………………………………………

………………………………………………………………………………………………

Thinking about your day to day jobs around the house, sports you play and hobbies you have.

At the moment which activities are you absolutely incapable?

1)	**4)**
2)	**5)**
3)	**6)**

Which activities cause you particular discomfort?

1)	**4)**
2)	**5)**
3)	**6)**

Do you need extra paid or unpaid help at home for house work you cannot do? **Yes / No**
If so, which?

1)	**3)**
2)	**4)**

What are your favourite past times / hobbies / recreations?

Recreation	Frequency before accident	Frequency now
1)		
2)		
3)		
4)		