Name:

Duties Under Duress Index

Have you continued to do any of the following activities despite the pain caused by your collision?

Work:

1. 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 didn't work.
- ☐ I cannot take time off, because I care for my own children.
- ☐ Other: _____.

2. I have experienced the following changes in my ability to perform work:
   - ☐ Mobility/Stability Problems:
     - ☐ Climbing
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Walking for long periods
   - ☐ Dexterity Problems:
     - ☐ Finger Movements
     - ☐ Wrist Movements
   - ☐ Problems with Fatigue:
     - ☐ Yes
     - ☐ No
   - ☐ Postural Difficulties:
     - ☐ Bending
     - ☐ Sitting for long periods
     - ☐ Standing for long periods
     - ☐ Stooping
   - ☐ Problems with Anxiety/Depression:
     - ☐ Yes
     - ☐ No
   - ☐ Problems with Vertigo or Spinning Sensations:
     - ☐ Dizziness
     - ☐ Giddiness
     - ☐ Sensation of Irregular Motion

- ☐ Sensation of Whirling Motion
- ☐ Problems with Tinnitus or Ringing in the Ears:
  - ☐ Yes
  - ☐ No
- ☐ Problems with Reduced Concentration:
  - ☐ Can't Concentrate
  - ☐ Can't Think Properly
  - ☐ Making Mistakes you otherwise wouldn't
- ☐ Pain:
  - ☐ Yes
    - Where: _____
  - ☐ No
- ☐ Duration of Symptoms:
  - ☐ I experienced problems doing normal work activities for ____ weeks.
  - ☐ Other 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.

Domestic Duties:

1. 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
   - ☐ Personal hygiene

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

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

4. I have the following numbers of children:
    - ☐ 0
    - ☐ 1
    - ☐ 2
    - ☐ 3
    - ☐ 4
    - ☐ 5
    - ☐ Other: ___

5. The number of my children in the following age category is:
    - ☐ 0-5 years
    - ☐ 5-11 years
    - ☐ 11+

6. Domestic Assistance:
    - ☐ I do receive domestic assistance
    - ☐ I do not receive domestic assistance

7. I have not been able to engage in sexual activity without pain/discomfort.
    - ☐ Yes
    - ☐ No

8. Duration of Symptoms:
    - ☐ I experienced problems doing my normal domestic activities for ___ weeks.
    - ☐ Other doctors have instructed me that my inability to perform my normal pre-accident domestic activities without pain is a permanent condition.
    - ☐ My problem is performing my normal domestic activities is ongoing.

Household:

1. 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: _____.

2. Duration of symptoms
   - ☐ I experienced problems being doing my normal household activities for ____ weeks.
   - ☐ Other doctors have instructed me that my inability to perform normal pre-accident household activities without pain is a permanent condition.
   - ☐ My problem in performing normal household activities is ongoing.

Studies/Educational Duties:

1. 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: _____

2. I have also experienced the following changes in my ability to perform at school as a result of injuries sustained from this collision:
   - ☐ Mobility/Stability Problems:
     - ☐ Climbing
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Walking for long periods
   - ☐ Dexterity Problems:
     - ☐ Finger Movements
     - ☐ Wrist Movement
   - ☐ 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:

- ☐ If so, where:_____.

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

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

Print Name: _____

Signature: _____ Date: _____

Patient No:_____