

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

### Duties Under Duress Summary

Complete the following questionnaire as it relates to how your injury(s) affect your performance of your living and work duties. Place a check in front of the day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Then check mark the appropriate box designating reason for difficulty. Include those duties/responsibilities which require that you reduce the time you are capable of performing them.

Job description: \_\_\_\_\_

**N/A Work Reason for the difficulty**  
\_\_\_\_ Lifting  Increased Pain  Restricted movement  Weakness  
\_\_\_\_ Bending  Increased Pain  Restricted movement  Weakness  
\_\_\_\_ Sitting  Increased Pain  Restricted movement  Weakness  
\_\_\_\_ Walking  Increased Pain  Restricted movement  Weakness  
\_\_\_\_ Computer duties  Increased Pain  Restricted movement  Fatigue  
Other: \_\_\_\_\_  Increased Pain  Restricted movement  Weakness

**N/A Studies/School Reason for the difficulty**  
\_\_\_\_ Lifting  Increased Pain  Restricted movement  Weakness  
\_\_\_\_ Bending  Increased Pain  Restricted movement  Weakness  
\_\_\_\_ Sitting  Increased Pain  Restricted movement  Weakness  
\_\_\_\_ Walking  Increased Pain  Restricted movement  Weakness  
\_\_\_\_ Computer duties  Increased Pain  Restricted movement  Fatigue  
\_\_\_\_ Studying  Increased Pain  Restricted movement  Fatigue  
Other: \_\_\_\_\_  Increased Pain  Restricted movement  Weakness

**N/A Domestic Duties Reason for the difficulty**  
\_\_\_\_ Vacuuming  Increased Pain  Restricted movement  Fatigue  
\_\_\_\_ Taking care of kids  Increased Pain/Anxiety  Restricted movement  Fatigue  
\_\_\_\_ Cleaning  Increased Pain  Restricted movement  Fatigue  
\_\_\_\_ Preparing Meals  Increased Pain  Restricted movement  Fatigue  
Other: \_\_\_\_\_  Increased Pain/Anxiety  Restricted movement  Fatigue

**N/A Household Duties Reason for the difficulty**  
\_\_\_\_ Yardwork  Increased Pain  Restricted movement  Fatigue  
\_\_\_\_ Transportation  Increased Pain/Anxiety  Restricted movement  Fatigue  
\_\_\_\_ Shopping  Increased Pain/Anxiety  Restricted movement  Fatigue  
\_\_\_\_ Taking out trash  Increased Pain  Restricted movement  Weakness  
Other: \_\_\_\_\_  Increased Pain/Anxiety  Restricted movement  Fatigue