

Date of Exam _____

HEALTH QUESTIONNAIRE

Examinee Name _____

Age _____ Height _____ Weight _____ Right _____ Left _____ Handed

HISTORY OF PRESENT CONDITION

My employer at the time of the injury was: _____

I was injured on: _____ I reported my injury to: _____

What happened: _____

My occupational title and job duties at the time of the injury/illness were: _____

The heaviest weight I lifted was _____ pounds, _____ times per day.

I began working for this employer in: Month _____ Year _____

PRIOR JOB HISTORY

<u>Years</u>	<u>Company</u>	<u>Job Title</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PRESENT JOB HISTORY

I am currently working: () No () Yes

With restrictions: () No () Yes

Please describe restrictions:_____

I am doing the same job duties as before the injury: () No () Yes

The last day I worked was_____ Still working? () No () Yes

I lost time from work from_____to_____ due to my injury.

I am working for a different employer: () No () Yes

If "Yes," name of new employer and job title:_____

TREATMENT FOLLOWING INJURY/CONDITION

Immediately following my injury, I received the following medical treatment in order (1, 2, 3 etc.) and please give names and first dates seen:

() None () Company Doctor_____ () Emergency Room_____

() Chiropractor_____ () Family Doctor_____ () Walk-In Clinic_____

() Other_____ Name of Facility_____

Treatments after the injury:

() Medication () Emergency Surgery () X-Rays () Other

Please explain:_____

I was admitted into a hospital: () No () Yes

Name of Hospital:_____

Were you ever denied medical treatment? () No () Yes

If yes, explain why treatment was denied:_____

FOLLOW-UP CARE

Please describe giving Dates received, Doctor Names and Body Parts:

() Surgery_____

() TENS Unit_____

() Physical Therapy_____

() Chiropractic_____

() Injections_____

DIAGNOSTIC STUDIES DONE

- () EMG_____
- () Bone Scan_____
- () MRI_____
- () CAT Scan_____
- () Other_____

PRESENT TREATMENT

I presently have a treating physician: () No () Yes

If "Yes," Name of Doctor_____

I have discussed returning to work with my doctor: () No () Yes

If "Yes," what was his/her opinion?_____

As a result of this injury, surgery has been considered: () No () Yes

Please explain:_____

My current treatment includes:_____

How often?_____

Treatment is helping: () No () Yes

If "No," when did treatment stop helping?_____

Please explain:_____

I am currently using an orthopaedic appliance: () No () Yes

() Cane () Cervical Collar () Crutches () Brace () Splint () TENS Unit

() Other, please describe:_____

How often is this appliance used?_____

I am using this appliance today: () No () Yes

MEDICATIONS

I am currently taking medication for my injury: () No () Yes

If "Yes," please list medications: _____

I am taking other medication: () No () Yes

If "Yes," please list medications and condition for which taken: _____

Please circle any medication(s) you have taken today listed above.

PRESENT COMPLAINTS

I currently have symptoms: () No () Yes

If you have pain, where is the pain located? _____

The pain remains in one place: () No () Yes

The pain is: () Occasional () Frequent () Constant

Please explain: _____

The pain is: () Sharp () Dull () Stabbing () Cramping

() Throbbing () Shooting () Aching () Burning

() Other _____

The intensity of my pain is: () Minimal () Slight () Moderate () Severe

I have: () Numbness () Tingling () Neither

Where? _____

What activities make the pain worse? _____

What makes the pain better? () Rest () Medication () Heat

() Other _____

My pain is: () Getting better () Worsening () Staying the same

PAIN DRAWING (on next page)

Please take a moment to fill out the Pain Drawing using symbols given.

Pain Drawing

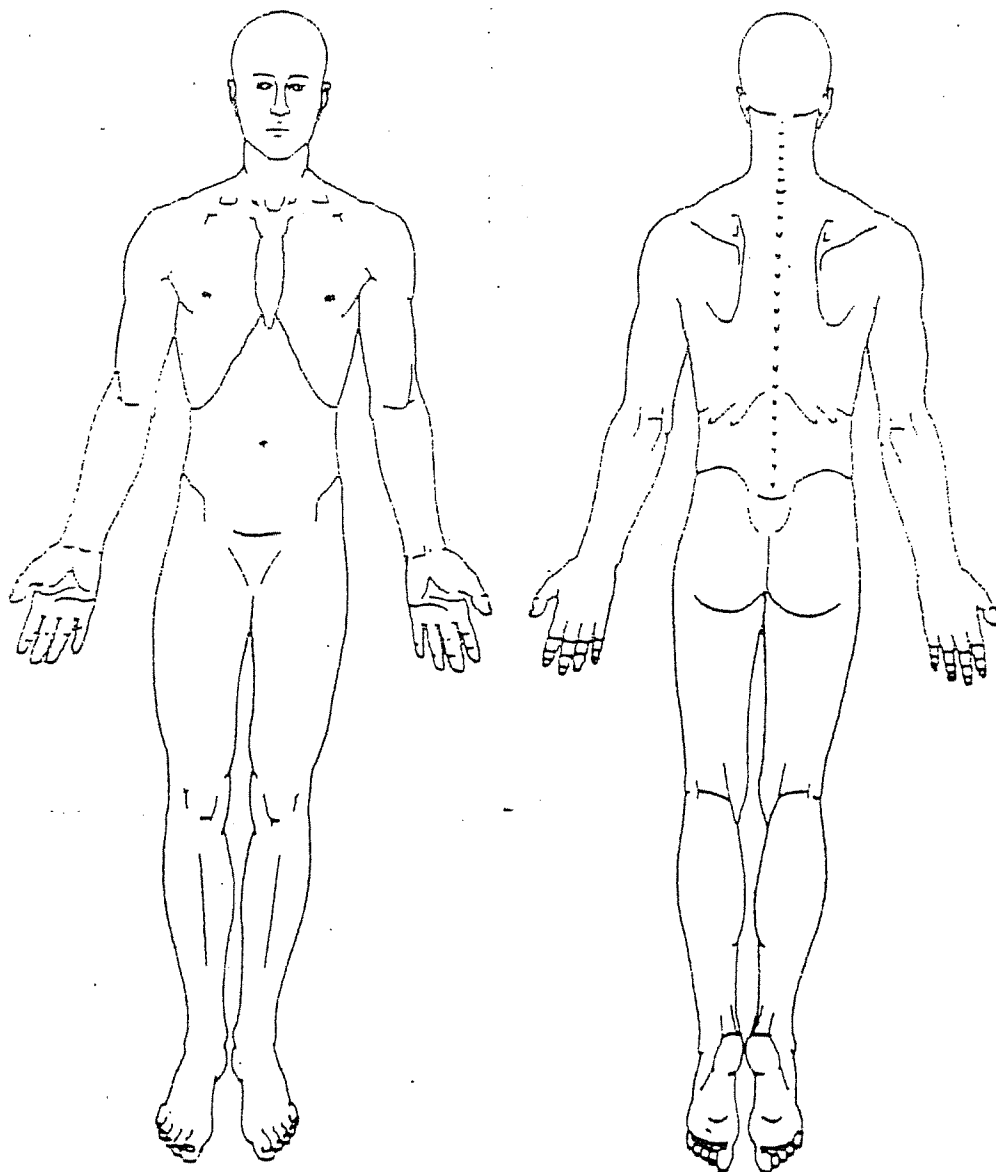
Patient Name: _____

Date: ___/___/___

Instructions

Indicate where your pain is located and what type of pain you feel at present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

/// Stabbing	XXX Burning	OOO Pins & Needles	=== Numbness
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OTHER INJURIES (before or after this injury)

Have you ever had prior or subsequent injury, pain or treatment to those body parts in your present claim? () No () Yes

If "Yes," please explain the injury treatment and the body parts involved:_____

I fully recovered from this previous injury: () No () Yes

If "No," please explain:_____

Have you had prior or subsequent Workers' Compensation claims (to any body part)? () No () Yes

Have you had prior or subsequent auto accident injury? () No () Yes

Have you had prior or subsequent emergency room visits for injury? () No () Yes

Have you had prior or subsequent personal injury claims for injury? () No () Yes

If "Yes," please explain:_____

GENERAL MEDICAL HISTORY

I have: () Diabetes () Heart Condition () High Blood Pressure

I have had other serious illnesses: () No () Yes

If "Yes," please explain:_____

I have had prior surgeries: () No () Yes

If "Yes," please explain:_____

I have been hospitalized other than for surgery: () No () Yes

If "Yes," please explain:_____

I have allergies: () No () Yes

I would rate my general health as: () Excellent () Good () Fair () Poor

Examinee Signature

Date

If you had help filling out this form, please write in that person's name and relationship to you:_____

THANK YOU!

PLEASE RETURN THIS FORM TO THE RECEPTIONIST AT THE FRONT DESK
WHEN YOU ARRIVE FOR YOUR APPOINTMENT

Table 18-4 Ratings Determining Impairment Associated With Pain

Name: _____

Date: _____

I. Pain (Self-report of Severity)

A. Rate how severe your pain is **right now, at this moment** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 No pain Most severe pain can imagine

B. Rate how severe your pain is **at its worst** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 None Excruciating

C. Rate how severe your pain is **on the average** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 None Excruciating

D. Rate how much your pain is **aggravated by activity** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 Activity does not aggravate pain Excruciating following any activity

Sum score of Section I: A-D = Total pain severity/4 = _____

E. Rate how **frequently** you experience pain (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 Rarely All of the time

Add total pain severity score (items A-D/4) to score for item E = _____

Total pain severity score (range from 0 to 20) = _____

II. Activity Limitation or Interference

A. How much does your pain interfere with your ability to **walk 1 block?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 Does not restrict ability to walk Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of groceries)? (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 Does not prevent from lifting 10 pounds Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for 1/2 hour?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 Does not restrict ability to sit for 1/2 hour Impossible to sit for 1/2 hour

D. How much does your pain interfere with your ability to **stand for 1/2 hour?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 Pain does not interfere with ability to stand at all Unable to stand at all

E. How much does your pain interfere with your ability to **get enough sleep?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 Does not prevent me from sleeping Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 Does not interfere with social activities Completely interferes with social activities

G. How much does your pain interfere with your ability to **travel up to 1 hour by car?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 Does not interfere with ability to travel 1 hour by car Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your **daily activities?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 Does not interfere with my daily activities Completely interferes with my daily activities

I. How much do you **limit your activities to prevent your pain from getting worse?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 Does not limit activities Completely limits activities

J. How much does your pain interfere with your **relationship with your family/partner/significant others?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 Does not interfere with relationships Completely interferes with relationships

K. How much does your pain interfere with your ability to **do jobs around your home?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 Does not interfere Completely unable to do any job around home

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
 Does not interfere at all My pain makes it impossible to shower or bathe without help

