Please

fill out and bring to your exam

FORM FOR EXAMINEE ASSESSMENT

Please answer all questions as completely as possible, so the doctor can properly evaluate you. This information is critical and necessary for your medical evaluation.

Location of Evaluation: _____

Name: _____ Date of Evaluation: _____

Address: _____
Street or P.O. Box City State Zip

Birthdate: ___/___/___ Sex: ❑ Male ❑ Female Age: _____

Height: _____ Weight: _____ Are you: ❑ Right or ❑ Left handed?

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Person filling out this form: ❑ Examinee ❑ Interpreter ❑ Other – Print name:
_____

Employer at the time of injury: _____

Address: _____
Street or P.O. Box City State Zip

Occupation at time of injury: _____ Job title: _____

Date of this injury: ___/___/___ Totally well before this injury? ❑ Yes ❑ No

PHYSICAL REQUIREMENTS OF THIS JOB:

Please state all information about your job <u>when you were injured</u> that would help assess whether you can do that job now.

1. Lift _____ pounds (most you <u>have</u> to lift) How often? _____
   In what position are you required to lift? _____
   Carry? _____

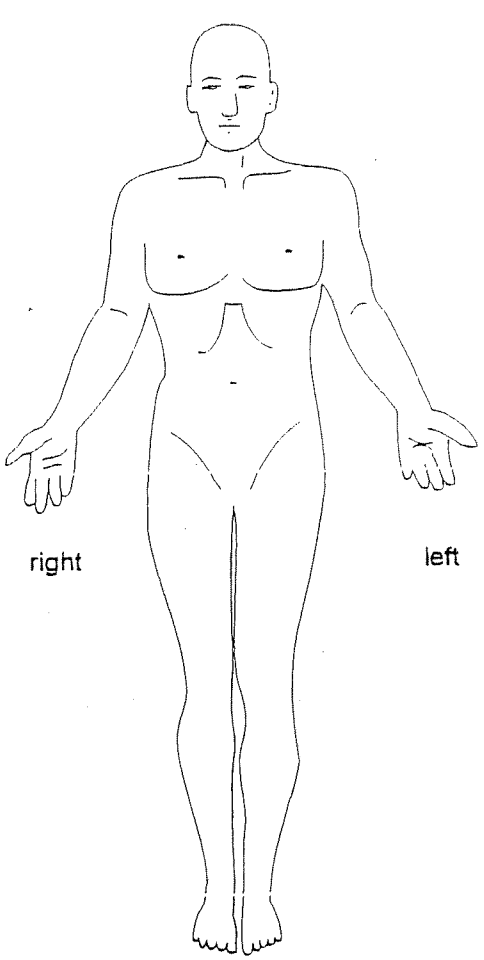
2. Do you do any task rapidly or repetitively? _____
   How often? _____ times per ❑ hour ❑ day ❑ week.
   How much force does it take to do that task? _____
   How much of each week do you do this repetitive task? _____

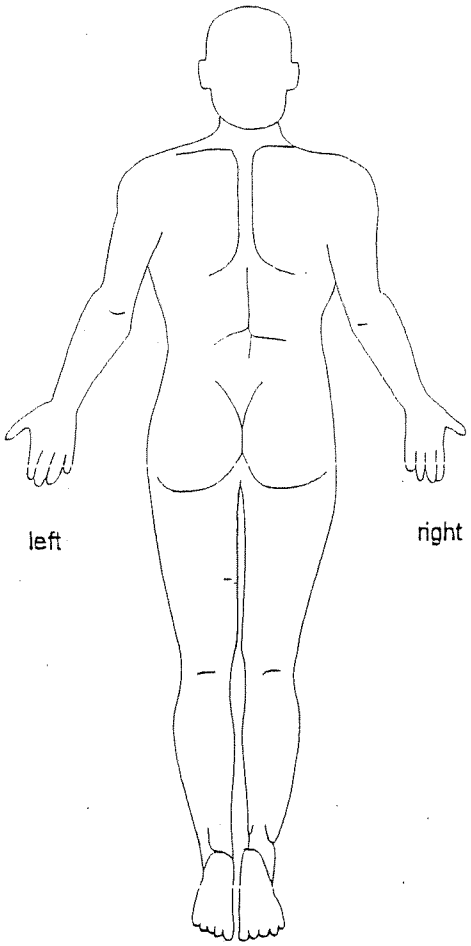
On the body chart below, mark the painful areas with the appropriate symbols:

Numbness	= = =
Pins and needles	+ + +
Burning	xxx
Stabbing	/ / /

Also, next to each painful area, write the two words, one word from each column, which best describes the intensity and frequency of your pain:

INTENSITY	FREQUENCY
Minimal	Occasional
Slight	Intermittent
Moderate	Constant
Severe	





Person filling out this page: ❑ Examinee ❑ Interpreter ❑ Other: Print name:

_____

3. Please describe your job in the space provided below.

INJURY:

How did you get hurt? Please describe the injury process in the space provided (Continues on to next page).

INJURY (Continued):

CURRENT COMPLAINTS:

Body Part	Complaint

PREVIOUS ACCIDENT/INJURY HISTORY:

Please list below any injuries you may have had prior to this injury. Include dates and list time off from work, if any. If we fail to list all these items, it may appear that YOU concealed the information intentionally. You should include:

- ☆ Auto accidents.
- ☆ Childhood accidents.
- ☆ Accidents you later recovered from.
- ☆ Accidents resulting in broken bones.
- ☆ Accidents with treatment by a chiropractor.
- ☆ Any chiropractic visit - for any reason.
- ☆ Injuries requiring stitches.
- ☆ Sports injuries.
- ☆ Injuries that did not occur at work.
- ☆ Any injury resulting in lost work time.
- ☆ "Slip and fall" accidents.
- ☆ Any injuries you remember, even if you can't remember the date.
- ☆ Injuries that you think do not matter in the connection with your legal case.

Date	Accident/Injury	Work related?	Time off work

SURGICAL HISTORY:

Please list below, beginning with the most recent, all surgical procedures you have had.

Date	Procedure	Outcome

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No How much? _____

Do you drink? ☐ Yes ☐ No How much? _____

EMPLOYMENT HISTORY:

List your employments from the most recent to the oldest.

Employer	Job title and duties	From - To

Do you participate in any of the following activities?

- ❑ Gardening
- ❑ Woodworking
- ❑ Wood cutting
- ❑ Carpentry
- ❑ Painting
- ❑ Farming
- ❑ Needlework
- ❑ Crochet/knitting
- ❑ Art
- ❑ Volleyball
- ❑ Hunting
- ❑ Fishing
- ❑ Bowling
- ❑ Softball/baseball
- ❑ Golf
- ❑ Tennis
- ❑ Weightlifting
- ❑ Swimming
- ❑ Jogging
- ❑ Biking
- ❑ Other _____

_____

_____

PRESENT MEDICATIONS:

Please list all of the medications you are currently taking in the space provided below.

_____

_____

_____

_____

OTHER MEDICAL HISTORY:

Do you have diabetes? ❑ Yes ❑ No

Do you have any other family members with diabetes? ❑ Yes ❑ No

List members: _____

Have you or your blood relatives inherited any disease from your/their blood relatives?

❑ Yes ❑ No

Who? _____

What? _____

Do you have gout? ❑ Yes ❑ No

Do you have arthritis? ❑ Yes ❑ No

Previous back/neck pain ❑ Yes ❑ No

Do you see any medical physician? ❑ Yes ❑ No

His/Her Name: _____

What medical conditions are you being treated for?

High Blood Pressure	❑ Yes	❑ No
Heart trouble	❑ Yes	❑ No
Kidney trouble	❑ Yes	❑ No
Stomach trouble	❑ Yes	❑ No
Eye trouble	❑ Yes	❑ No
Ear trouble	❑ Yes	❑ No

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

If yes, explain why treatment was denied:_____

_____

_____

Place a mark in the YES or NO box in the following list of symptoms.

HEAD AND NECK

Yes	No	
☐	☐	Severe headaches
☐	☐	Dizzy spells
☐	☐	Failing vision
☐	☐	Double vision
☐	☐	Eye Pain
☐	☐	See "Floating lights"
☐	☐	Severe hearing loss
☐	☐	Ringing in ears
☐	☐	Pain in ears
☐	☐	Discharge from ear
☐	☐	Repeated nosebleeds
☐	☐	Chronic nose obstruction
☐	☐	Chronic sore tongue
☐	☐	Persistent sore gums
☐	☐	Prolonged hoarseness
☐	☐	Persistent neck rigidity
☐	☐	Swelling in neck

HEART AND LUNGS

☐	☐	Chest pain on effort
☐	☐	Skipping heart beats
☐	☐	Difficulty breathing
☐	☐	Must sit up to breath easily
☐	☐	Chronic cough
☐	☐	Spitting up blood
☐	☐	Night sweats
☐	☐	Swollen ankles
☐	☐	Any heart defects

STOMACH AND INTESTINES

☐	☐	Chronic abdominal pain
☐	☐	Persistent nausea
☐	☐	Heart burn
☐	☐	Appetite Loss
☐	☐	Vomit blood
☐	☐	Skin turns yellow
☐	☐	Chronic diarrhea
☐	☐	Black tarry stools
☐	☐	Blood from rectum
☐	☐	Clay colored stools
☐	☐	Habitual constipation
☐	☐	Hemorrhoids

URINARY TRACT, ETC.

Yes	No	
☐	☐	Excess urination
☐	☐	Urinary shutdown
☐	☐	Scanty urination
☐	☐	Excess night-time urination
☐	☐	Blood in urine
☐	☐	Pain with urination
☐	☐	Leakage of urine
☐	☐	Passed any stones
☐	☐	Any bedwetting
☐	☐	Any retention of urine

FOR WOMEN

☐	☐	Painful menstruation
☐	☐	Excess menstruation
☐	☐	Bleed between periods
☐	☐	Any missed periods
_____		Number of pregnancies
_____		Number of living children

MUSCLES, JOINTS AND NERVES

☐	☐	Any tingling sensations
☐	☐	Any numbness
☐	☐	Disturbance in walking
☐	☐	Any muscle jerking
☐	☐	Any paralysis
☐	☐	Any shaking
☐	☐	Any limited motions
☐	☐	Any joint problems
☐	☐	Nervous breakdown
☐	☐	Any strokes
☐	☐	Any memory loss
☐	☐	Personality changes
☐	☐	Speech disturbances
☐	☐	Any seizures
☐	☐	Any alcohol problem
☐	☐	Any drug problem
☐	☐	Any mental problem
☐	☐	Any varicose veins

ALLERGIES

Yes	No	
☐	☐	Any food allergies

Please list:

_____

_____

_____

_____

☐ ☐ Any medication allergies

Please list:

_____

_____

_____

_____

☐	☐	Any Inhalation allergies
☐	☐	Any contact allergies
☐	☐	Adhesive tape allergy
☐	☐	Metal allergy
☐	☐	Subject to skin rash

Do you have any current health problems?

☐ ☐

If so, please list and describe:

_____

_____

_____

_____

_____

_____

_____

_____

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

M. How much does your pain interfere with your ability to **write or type?** (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 write or type

N. How much does your pain interfere with your ability to **dress yourself**? (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 dress myself

O. How much does your pain interfere with your ability to **engage in sexual activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it almost impossible to engage in any sexual activity

P. How much does your pain interfere with your ability to **concentrate**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Never — All the time

Sum score of Section II
A-P = Total score for activity limitation/16 =
Mean activity limitation = _____

III. Individual's Report of Effect of Pain on Mood

A. Rate your **overall mood** during the past week: (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Extremely high/good — Extremely low/bad

B. During the past week, how **anxious or worried** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

C. During the past week, how **depressed** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all depressed — Extremely depressed

D. During the past week, how **irritable** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all irritable — Extremely irritable

E. In general, how anxious/worried are you about performing activities because they **might make your pain/symptoms worse**?

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

Sum score of Section III.
A-E = Total pain impairment attributed to mood state/5 =
Mean score = _____

Assess Whether the Individual Is at MMI

This concept is particularly important in the assessment of pain-related impairment. A person should not be judged medically stable, and therefore ratable, unless he or she has undergone a thorough evaluation for the entire range of factors that can affect pain and has undergone a vigorous trial of rehabilitative treatment.

For example, there may be no further orthopedic interventions available for a lumbar pseudarthrosis. Spinal arachnoiditis may be refractory to any intervention. Yet in both cases, appropriate pain management may reduce all the components of impairment, with reduced pain severity, functional restoration, and mood normalization. Consultation with a specialist in pain medicine may be required to determine whether the impairment is fixed or potentially useful treatments are available.

Determine the Severity of the Pain

Although absolute quantification of pain is not possible, severity may be estimated using, for example, a visual analog scale, a numeric, or a box-rating scale. A horizontal or vertical line of known length is anchored by "no pain at all" at one end and "worst pain ever" at the other. A line of consecutive boxes also anchored with these end points, with a number in each one and in which the individual is asked to place an "X" in the box, may be of particular use because some people have difficulty understanding how to use a VAS scale.[3] It is useful to obtain least, worst, and current levels, as well as the usual level. Exacerbating and mitigating factors should be sought. The character or quality of pain may assist with diagnosis and help establish that the pain is compatible with a known medical syndrome.