RHEUMATOLOGY AND INTERNAL MEDICINE QUESTIONNAIRE

Name: _____

Date: _____

Height: _____ Weight: _____ Age: _____ Right-handed _____
Left-handed _____

Date of Injury: _____

Briefly describe how you were injured, including which body parts were injured. If there is more than one injury, please provide dates for all of them separately, as well as the body parts involved.

_____

_____

_____

_____

_____

OCCUPATIONAL HISTORY & JOB DESCRIPTION

The following questions relate specifically to the job that you were performing at the time of your injury for which you are being examined today. If you have subsequently switched employment or had a change from your duties that you were performing at the time of your injury, please do not describe your new duties in this section. **Again, this section relates specifically to those duties you were performing at the time of your injury.**

1. The injury you are being examined for today occurred while you were employed by:

2. What was your occupational title for the employer named above?

3. What were the duties of your job? Please list your general job tasks. Only a brief description of each task is necessary. (For example, a secretary might list: a) type; b) take dictation; c) operate a phone system.)

   Your job duties:

   (a) _____

   (b) _____

   (c) _____

   (d) _____

Do you do any of the following activities?					
	Yes	No		Yes	No
Driving			Housecleaning		
Walking			Shopping		
Cooking			Physical exercise		

Can you:	Normal	Limited	Not at all
Bend?			
Stoop?			
Walk? *			
Sit? *			
Climb?			
Lift?			

* If these activities are limited, please describe your limitations?:			
Walk	Blocks	Miles	Minutes
Sit			Minutes
Lifting			Pounds
Description of limitation:			

Describe the maximal physical activities you engage in:

Has anyone assisted you with this form?	Yes	No
If yes, who?		

ACTIVITY	TIME SPENT			
	None at All	Up to 1/3 of Workday	Up to 2/3 of Workday	More Than 2/3 of Workday
Twisting (your torso or lower back)				
Walking				
Walking on uneven terrain				
Simple (or light) grasping with hands				
Fine manipulative hand motions (e.g., circuit board work, typing, etc.)				
Pushing and pulling				
Reaching overhead				
The use of foot controls				

a) What was the maximum amount lifted in your job? _____

b) How many times a day were you required to lift this weight? _____

c) What type of floor surface did you work on while at work?

Cement ____
Wood ____
Carpet ____
Brick ____
Uneven terrain ____
Tile ____
Other _____

7. Please list all injuries, by body part and date, which you had while employed by the employer listed in Question 1. If possible, also indicate the amount of time you lost from work, if any, including the time lost due to the injury for which you are being examined today.

a) _____
b) _____
c) _____
d) _____
e) _____

PRIOR EMPLOYMENT

8. Last Prior Employer. Respond to the following questions beginning with the employer you had prior to the employer you were working for at the time of your injury:

a) Name of last prior employer _____

b) Location _____

c) Occupation/work duties _____

d) Period of prior employment: From _____ To _____

9. Second to Last Prior Employer. Respond to the following questions regarding your employer prior to the one named in Question 8 above:

a) Name of second to last prior employer _____

b) Location _____

c) Occupation/work duties _____

_____

d) Period of prior employment: From _____ To _____

10. Third to Last Prior Employer. Respond to the following questions regarding your employer prior to the one named in Question 9 above:

a) Name of third to last prior employer _____

b) Location _____

c) Occupation/work duties _____

_____

d) Period of prior employment: From _____ To _____

SIMULTANEOUS EMPLOYMENT

11. Did you work for any other employer at the same time that you were working for the employer named originally in Question 1?

Yes _____ No _____

If no, go on to question number 12.

If yes, then respond to the following:

a) Name of employer _____

b) Location _____

c) Occupation/work duties _____

d) Hours worked per week _____

e) Dates of employment _____

12. Have you worked anywhere after the employer originally named in Question 1?

Yes _____ No _____

If no, go on to question number 14.

If yes, then respond to the following:

a) Are you currently employed there? Yes _____ No _____

b) By whom are you currently employed? _____

c) Where is your current employer located? _____

d) What are your current occupation/work duties? _____

e) When did your current employment begin? _____

13. Respond to the following questions beginning with your first employer after the injury for which you are being examined today.

a) Name of first subsequent employer _____

b) Location of employment? _____

c) Occupation/work duties? _____

d) Period of subsequent employment: From _____ To _____

a) Name of second subsequent employer? _____

b) Location of employment? _____

c) Occupation/work duties? _____

d) Period of subsequent employment: From _____ To _____

CURRENT COMPLAINTS AND/OR TREATMENT

14. List or describe the main symptoms and problems for which you are being evaluated today:

15. When and how did this (or these) problem(s) start?

16. List all the physicians who you've seen for this problem:

Name	Specialty	Location of Doctor	Date	Who Referred You?

17. Check all the tests you have had related to this treatment:

___ EEG
___ ENG
___ Hearing test
___ X-rays of: _____
___ Myelogram
___ Spinal tap
___ Blood tests
___ MRI of: _____
___ Nerve tests (EMG/NCV)
___ Urine tests
___ Psychological testing
___ CT scan of: _____
___ Endoscopy
___ Other: _____

18. Check all treatments you have had:

___ Physical therapy
___ Surgery
___ TENS (nerve stimulator)
___ Shots or injections
___ Chiropractic
___ Biofeedback
___ Traction
___ Hypnosis
___ Acupuncture
___ Braces or corset
___ Pain management
___ Vocational rehabilitation
___ Medications
___ Other _____

19. Who is your current treating doctor for this problem?

20. What is the date of your last visit to this doctor?

21. What treatment are you currently receiving?

22. Have you ever had the same or similar symptoms in the past? Yes_____ No_____

If yes, please describe when and briefly give the circumstances connected with the prior symptoms.

_____

_____

REVIEW OF SYMPTOMS

Please check those symptoms that apply:

SYMPTOM	Now	In Past	SYMPTOM	Now	In Past
Tension headache			Uncontrollable movement		
Migraine headache			Tremors		
Neck pain			Muscle tics/twitches		
Blurred vision			Muscle cramps		
Double vision			Muscle pain		
Failing vision			Muscle weakness		
Spots before eyes			Muscle shrinkage		
Vision blackouts			Muscular paralysis		
Hiccups			Poor coordination		
Excessive yawning			Poor balance		
Hoarseness of voice			Falling spells		
Ringing in ears			Low back pain		
Lightheadedness			Mid-back pain		
Poor equilibrium			Hip/buttock pain		
Dizziness/vertigo			Numbness/tingling		
Fainting spells			Burning sensations		
Convulsions/seizures			Joint pain/stiffness		
Blackouts			Joint swelling		
Cold fingers and toes			Eczema		
Blood in stool			Skin rash		
Hemorrhoids			Easy bruising		
Constipation			Hard to stop bleeding		
Burning urination			Frequent nausea		
Frequent urination			Frequent vomiting		
Blood in urine			Heartburn/indigestion		
Oral or nasal sores/ulcers			Poor circulation		
Joint stiffness					

Problems with:	Now	In Past	Problems with:	Now	In Past
Undesired weight loss			Controlling bowels		
Undesired weight gain			Controlling urination		
Shortness of breath			Obtaining an erection		
Chest pain					
Difficulties with:	**Now**	**In Past**	**Difficulties with:**	**Now**	**In Past**
Smelling			Recurrent fears		
Tasting			Worry about health		
Chewing			Panic attacks		
Speaking			Hyperventilation		
Swallowing			Frequent crying		
Reading			Feeling persecuted		
Writing			Hearing voices		
Memory			Hallucinations		
Understanding			Chronic worry		
Forgetfulness			Irritability		
Thinking clearly			Moodiness		
Concentration			Feeling stress		
Periods of confusion			Inability to relax		
Chronic fatigue			Overreacting emotionally		
Loss of interest			Explosive temper		
Excessive drowsiness			Change in personality		
Trouble sleeping			Nervous breakdown		
Feeling depressed			Drug use		
Feelings of hopelessness			Heavy alcohol use		
Thoughts of suicide			Suicide attempts		

Were you ever denied medical treatment? Yes_____ No_____

If yes, explain why treatment was denied:_____

_____

_____

FAMILY HISTORY

List any family members who have or have had:			
Epilepsy or seizures		High blood pressure	
Neuromuscular disease		Stroke	
Nervous or medical conditions		Chronic pain	
Alcoholism		Other (describe)	
Cancer		Other (describe)	
Diabetes		Other (describe)	

MEDICAL HISTORY

Has a doctor ever said you had any of the diseases or conditions listed below?
If yes, are you receiving treatment now?

Disease/Condition	Now	Treatment	Disease/Condition	Now	Treatment
Arthritis			Heart disease		
Gout			Heart murmur		
Asthma			Gallbladder		
Allergies			Cirrhosis		
Lung disease			Hepatitis		
Tuberculosis			Colon/bowel disease		
Emphysema			Cancer or tumor		
Anemia			Stomach problems/ulcer		
Thyroid disease			Venereal disease		
Diabetes			Other diseases or conditions:		
High blood pressure			Fibromyalgia		

Check any of the following operations you have had:					
Tonsils		Stomach		Ovary	
Appendix		Gallbladder		Breast	
Hernia		Kidney		Thyroid	
Hemorrhoids		Tubal ligation		Laminectomy (neck)	
Colon		Hysterectomy		Laminectomy (back)	

Other diseases, conditions, or operations you have undergone:

SUBSTANCE USE

Please indicate whether or not you use the following items and, if yes, what type and quantity:						
	Current Use				Past Use	
Substance	Yes	No	Type	Amount per day	Yes	No
Tobacco						
Alcohol						
Coffee						

HOSPITALIZATIONS

List all hospitalizations other than those for operations:	
Year	Reason

MEDICATIONS

List all medications you take. Include vitamins, hormones and non-prescription drugs.		
Name	Dose	How often?

List all medications to which you are allergic:

TRAUMAS/INJURIES

List all injuries (broken bones, sprains, concussions, lacerations, etc.):

Auto Accident	Other	Year	Type of Injury	Treatment

Industrial Injuries:

Date	Type of injury (Body parts involved)	Outcome

Have you ever been involved in a lawsuit or any type of legal action having to do with accidents or health matters?

YES _____ NO _____

If yes, please list all such occurrences:

Year	Description	Outcome

ACTIVITY LEVEL

List all hobbies, physical activities and interests	Now	Prior to Injury

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.[21] 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.

Epworth Sleepiness Scale

Name: _____

Date: _____

Your age: (Yr) _____ Your sex: ❑ Male ❑ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:-

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total	

Score:

0-10	Normal range
10-12	Borderline
12-24	Abnormal