Date: __/__/____

HEALTH QUESTIONNAIRE

Examinee Name_____ Age_____ Height_____ Weight_____

Examinee Social Security #: _____/_____/_____ Examinee Date of Birth: ___/___/_____

Date of Injury:_____ R_____ L_____ Handed

PRESENT JOB HISTORY

Your employer at the time of the injury was:_____

Job Title:_____ Date you were hired: ___/___/____

JOB DUTIES

Your occupational job duties at the time of the injury/illness were:_____

_____

_____

_____

The heaviest weight you lifted was_____ pounds. How many times per day_____

Did you do any: [ ] Sitting [ ] Standing [ ] Walking [ ] Lifting [ ] Climbing

[ ] Kneeling [ ] Squatting [ ] Bending [ ] Crawling

[ ] Pushing [ ] Pulling [ ] Reaching above shoulder level.

Were you hired with restrictions: ( ) No ( ) Yes

CURRENT WORK STATUS

Do you still Work for this employer: ( ) No ( ) Yes

Are you currently working: ( ) No ( ) Yes

With restrictions: ( ) No ( ) Yes

Please describe restrictions:_____

_____

Are you doing the same job duties as before the injury: ( ) No ( ) Yes

The last day you worked was_____

You 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:_____

PRIOR JOB HISTORY

Years	Company	Job Title

Have you ever been injured on the job: ( ) No ( ) Yes

If yes give details: _____

HISTORY OF PRESENT CONDITION

Date of Injury: / / Who is your current PTP: _____ since: ___/___/____

Describe what happened: _____

TREATMENT FOLLOWING INJURY/CONDITION

Immediately following the injury, what care was provided and please give names and first dates seen:

( ) None ( ) Company Doctor_____ ( ) Emergency Room_____

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

( ) Other_____

What was done: Exam( ) X-rays( ) Medications( ) Physical Therapy( ) Chiropractic( )

Other:_____

Were you: Taken off work( ) If so, how long:_____ Put on modified duty( ) Kept working( )

FOLLOW-UP CARE

After initial care list other care and referrals you received. Please describe giving Dates received and Doctor Names:

( ) Surgery_____ ( ) Physical Therapy_____

( ) Chiropractic_____ ( ) Injections_____

( ) Psych Evaluation_____ ( ) Sleep Study_____

( ) Internal Medicine_____ ( ) Functional Capacity Assessment_____

( ) Pain Management_____ ( ) Other:_____

DIAGNOSTIC STUDIES DONE

( ) EMG/NCV_____

( ) MRI_____

( ) Bone Scan_____

( ) CAT Scan_____

( ) Other_____

PRESENT TREATMENT

Describe current treatment and by whom:_____

_____

How often?_____

Is treatment helping: ( ) No ( ) Yes
Please explain:_____

Are you currently using an orthopaedic appliance: ( ) No ( ) Yes

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

( ) Other, please describe:_____

How often is this appliance used?_____

Are you using this appliance today: ( ) No ( ) Yes

PAST OR SUBSEQUENT INJURIES

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: _____

_____

_____

_____

Did you fully recovered from this previous injury: ( ) No ( ) Yes

If "No," please explain: _____

Have you had prior or subsequent Workers' Compensation claims: ( ) 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

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

Other serious illnesses: ( ) No ( ) Yes

If "Yes," please explain: _____

_____

_____

Prior surgeries: ( ) No ( ) Yes

If "Yes," please explain: _____

_____

Hospitalized other than for surgery: ( ) No ( ) Yes

If "Yes," please explain: _____

Do you have allergies: ( ) No ( ) Yes

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

MEDICATIONS

Are you currently taking medication for your injury: ( ) No ( ) Yes

If "Yes," please list medications: _____

_____

Are you taking medications for other health issues: ( ) No ( ) Yes

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

_____

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

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

If yes please explain: _____

PRESENT COMPLAINTS

Do you currently have symptoms: ( ) No ( ) Yes

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

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

Please explain: _____

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

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

( ) Other _____

Is the intensity of your pain: ( ) Minimal ( ) Slight ( ) Moderate ( ) Severe

Do you have: ( ) Numbness ( ) Tingling ( ) Neither

If so Where: _____

What activities make the pain worse? _____

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

( ) Other _____

Is your pain: ( ) Getting better ( ) Worsening ( ) Staying the same

_____
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

Revised DrT:07/09

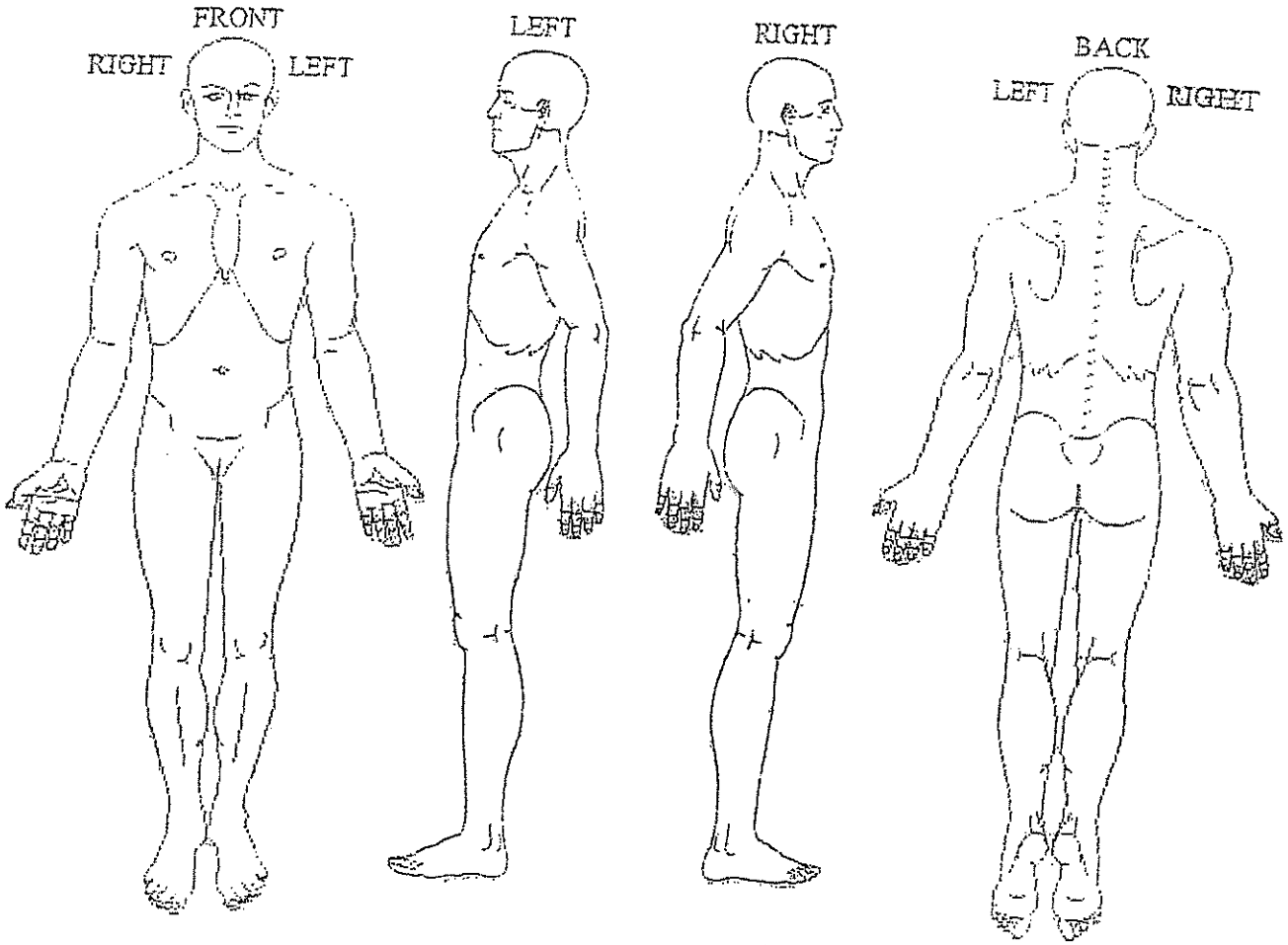
Complete this drawing for your symptoms at this time (Do not show where symptoms used to be).

PAIN DRAWING

Using the key, describe your present ailment

KEY

Major Pain:	XXX	Tingling:	YYY
Secondary Pain:	///	Burning:	ZZZ
		Loss of Sensation:	OOO



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

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

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

/
\ =

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

5
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