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

Years	Company	Job Title

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.

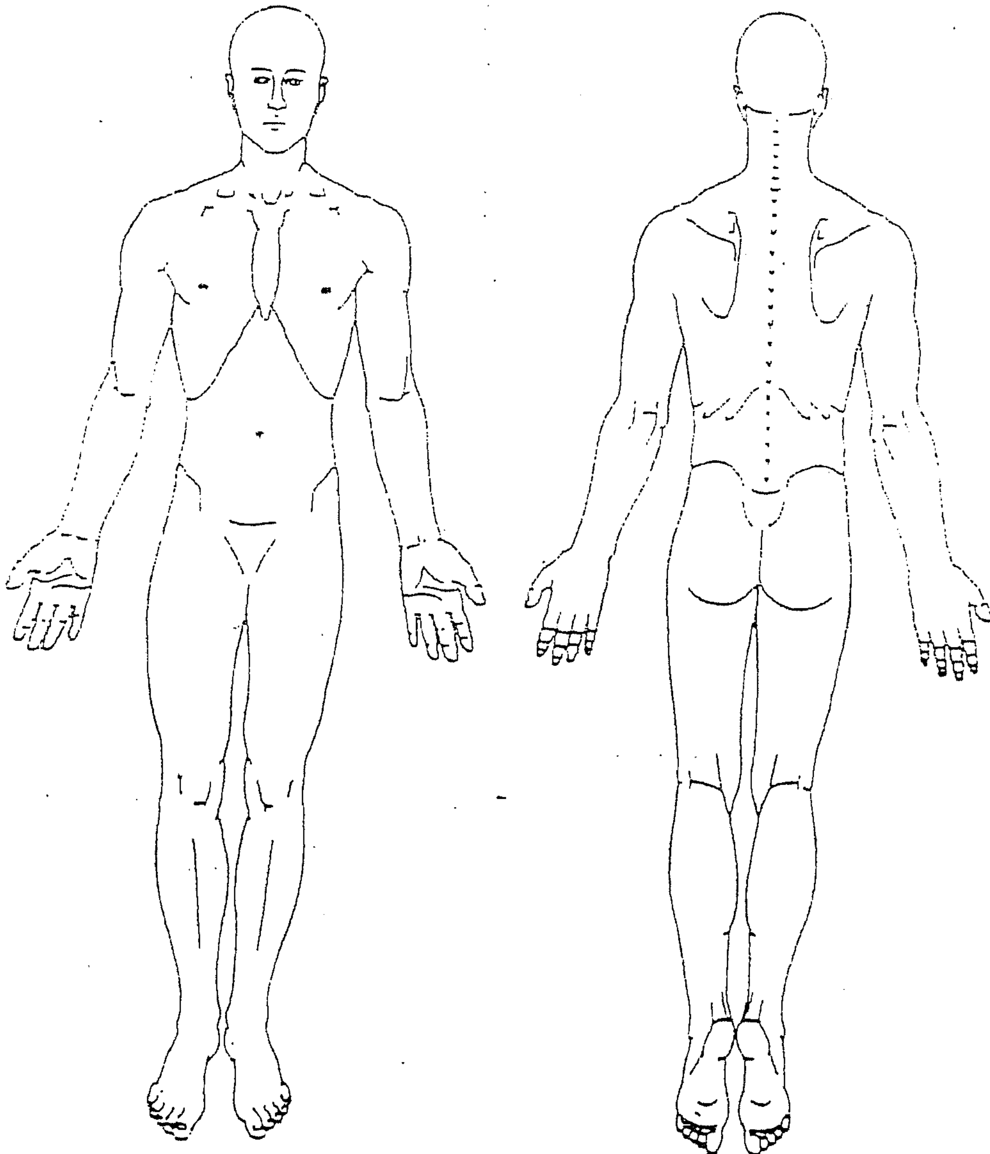
Pain Drawing

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



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

Revised HQ:05/09

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.[31] 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.