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PATIENT QUESTIONNAIRE

Name _____ Date of Examination _____

Complete Address _____

DOB _____ Age _____ Soc. Sec. # _____ Telephone Number () _____

Height ___ ft. ___ in.

Right-handed

Left-handed

Weight _____ lbs.

SEX: Female

Male

Date(s) of Injury _____ Time of Injury: _____

WORK HISTORY

Name of employer at time of injury(ies): _____

When did you start working for the company? _____

Date you last worked: _____

Job title: _____

Describe your duties: _____

What physical activities were required on your job? (For example: Sit, stand, walk, bend, reach, knee, climb, crawl, crouch, bend, ascend or descend stairs or ladders, push, pull, lift, carry, etc.)

How much were you required to lift and/or carry as part of your job duties? _____

How much can you lift and/or carry at this time? _____

How much could you lift and/or carry before your present injury? _____

Hours worked per day _____ per week _____ What were your hours? _____ a.m. to _____ p.m.

CURRENT WORK STATUS

Are you still employed by the company? yes no

Are you currently working for them? yes no If Yes: regular job duties light job duties

What are your light job duty restrictions? _____

If you are not currently working, when did you last work for company (date)? _____

Are you disabled? yes no

Are you currently receiving disability benefits as a result of the work injury? yes no

If yes, from whom? Workers' compensation insurance carrier

State Disability Insurance fund

Present Employer & Job Title: _____

OCCUPATIONAL HISTORY

Who did you work for before working for this employer? _____

How long did you work there? _____

What was your job title? _____

What were your job duties? _____

Did you have any injuries on that job? yes no

If yes, what is the date of the injury? _____

What were your injuries? _____

Was there a settlement? yes no If yes, how much was the settlement? _____

HISTORY OF INJURY

In your own words, please describe the injury and include... What were you doing? How did it occur?

What part(s) of your body was hurt? (Use other side if necessary)

Did you report the injury? _____ If so, to whom? _____ When? _____

Describe your medical treatment:

(Where, when, by whom, what type. Where were you seen first? What treatment did you receive? Were you referred elsewhere?)

Were you returned to work? _____ If yes: modified **or** regular job duties.
 If you returned to work with restrictions, what were your restrictions? _____

Were you later taken off work? _____ If so, when and by whom? _____

Were x-rays or other special studies done? yes no If Yes: which body part(s): _____

| SPECIAL STUDIES | Body Part | Date Performed | Location Performed | Result |
|-----------------|-----------|----------------|--------------------|--------|
| EMG, NCV | | | | |
| CT Scan | | | | |
| MRI | | | | |
| Bone Scan | | | | |
| Myelogram | | | | |
| Arthrogram | | | | |
| Other | | | | |

Did you receive physical therapy? yes no If yes, for how long? _____
 How often? _____

Did this treatment help? yes no

Did you have surgery? yes no
 If yes, when? _____

Are you still receiving treatment? yes no
 If yes, what type? _____

Describe any further medical and/or chiropractic treatment you have received to this date, as a result of the injury(ies): _____

Please list the names and dates from the first doctor you saw to the present:

| Name | Specialty | City | Referred By | Exam Date |
|-------|-----------|-------|-------------|-----------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

With the treatment provided to date, do you feel your condition is:

Fully recovered Improved No change Worse

Explain: _____

Have you missed any time from work because of the injury? yes no
 If yes, what was your first day of lost time? _____
 If yes, when did you return to work? _____
 Were you ever told to return to modified work? yes no
 What were your restrictions _____
 If yes, did you return to work? yes no When? _____
 Is modified work available? yes no
 When do you expect to return to your regular work? _____

CURRENT MEDICAL TREATMENT

Are you still seeing a doctor at this time? yes no If yes, date last seen: _____
 Next appointment _____ Doctor's name _____ MD, DC
 How often? Weekly Monthly As Needed Other _____

Are you taking any medications? yes no
 If yes, name of medications: _____
 How often do you take them? _____
 Does the medication help you? _____

Are you currently receiving physical therapy? yes no
 Is physical therapy helping? _____

PRESENT COMPLAINTS

(per body part)

Please: ONLY COMPLETE the body parts that were injured.

NECK

Are you still having pain? yes no If so, which part? _____
 Describe the pain: [Constant (100%), frequent (75%), intermittent (66%), occasional (33%)] _____
 How does the pain feel? (Sharp, dull, aching, stabbing, burning, etc.) _____
 What makes the pain worse? _____
 What decreases the pain? _____

Using the pain scale below, how would you describe your pain? Please circle the number that best estimates the amount of pain:

Before the injury: no pain ←-----→ worst pain imaginable
 0 1 2 3 4 5 6 7 8 9 10

Your pain now: no pain ←-----→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Does your present pain travel to other parts of the body? yes no
If yes, where? _____

Do you experience stiffness? yes no

Do you experience weakness? yes no

Do you experience numbness? yes no

Do you experience tingling? yes no If so, where? _____

Do you have swelling? yes no

Any popping of the joints? yes no

Any locking of the joints? yes no

Any giving way of joints? yes no

Is there increased pain with coughing or sneezing? yes no

SHOULDERS

Are you still having pain? yes no If so, which shoulder? _____

Describe the pain: [Constant (100%), frequent (75%), intermittent (66%), occasional (33%)] _____

How does the pain feel? (Sharp, dull, aching, stabbing, burning, etc.) _____

What makes the pain worse? _____

What decreases the pain? _____

Using the pain scale below, how would you describe your pain? Please circle the number that best estimates the amount of pain you are currently experiencing.

Before the injury: no pain ←-----→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Your pain now: no pain ←-----→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Does your present pain travel to other parts of the body? yes no
If yes, where? _____

Do you experience stiffness? yes no

Do you experience weakness? yes no

Do you experience numbness? yes no

Do you experience tingling? yes no

Do you have swelling? yes no

Any popping of the joints? yes no

Any locking of the joints? yes no

Any giving way of joints? yes no

Have you had prior surgery? yes no

If so, when? _____

Do you have pain raising your hand above shoulder level? yes no

Have you had a shoulder dislocation? yes no

ELBOWS

Are you still having pain? yes no If so, which elbow? _____

Describe the pain: [Constant (100%), frequent (75%), intermittent (66%), occasional (33%)] _____

How does the pain feel? (Sharp, dull, aching, stabbing, burning, etc.) _____

What makes the pain worse? _____

What decreases the pain? _____

Using the pain scale below, how would you describe your pain? Please circle the number that best estimates the amount of pain you are currently experiencing.

Before the injury: no pain ←-----→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Your pain now: no pain ←-----→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Does your present pain travel to other parts of the body? yes no

If yes, where? _____

Do you experience stiffness? yes no

Do you experience weakness? yes no

Do you experience numbness in fingers? yes no If so, which fingers? _____

Do you experience tingling? yes no If so, where? _____

Do you have swelling? yes no

Any popping of the joints? yes no

Any locking of the joints? yes no

Any giving way of joints? yes no

Did you have any surgeries? yes no If so, when? _____

HIPS

Are you still having pain? yes no If so, which hip? _____

Describe the pain: [Constant (100%), frequent (75%), intermittent (66%), occasional (33%)] _____

How does the pain feel? (Sharp, dull, aching, stabbing, burning, etc.) _____

What makes the pain worse? _____

What decreases the pain? _____

Using the pain scale below, how would you describe your pain? Please circle the number that best estimates the amount of pain you are currently experiencing.

Before the injury: no pain ←-----→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Your pain now: no pain ←-----→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Does your present pain travel to other parts of the body? yes no
If yes, where? _____

Do you experience stiffness? yes no

Do you experience weakness? yes no

Do you experience numbness? yes no

Do you experience tingling? yes no If so, where? _____

Do you have swelling? yes no

Any locking of the joints? yes no

Do you have any problems walking? yes no

Do you have any problems bending/squatting/pushing/pulling? yes no

Do you have any problems lifting? yes no How much can you lift? _____

Do you have any bladder or bowel problems? yes no

Is there increased pain with coughing or sneezing? yes no

Do you use any assistive device(s)? (cane, support, corset, etc.) _____

KNEES

Are you still having pain? yes no If so, which knee? _____

Describe the pain: [Constant (100%), frequent (75%), intermittent (66%), occasional (33%)] _____

How does the pain feel? (Sharp, dull, aching, stabbing, burning, etc.) _____

What makes the pain worse? _____

What decreases the pain? _____

Using the pain scale below, how would you describe your pain? Please circle the number that best estimates the amount of pain you are currently experiencing.

Before the injury: no pain ←-----→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Your pain now: no pain ←-----→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Does your present pain travel to other parts of the body? yes no
If yes, where? _____

Do you experience stiffness? yes no

Do you experience weakness? yes no

Do you experience numbness? yes no

Do you experience tingling? yes no If so, where? _____

Do you have swelling? yes no

Do you have swelling? yes no

Any popping of the joints? yes no

Any locking of the joints? yes no

Any giving way of joints? yes no

Does your ankle feel stable? yes no

Do you have problems squatting, ascending and descending stairs? yes no

Do you have difficulty walking on uneven ground? yes no

Have you had prior injuries? yes no If yes, when? _____

Have you had prior surgeries? yes no If yes, when? _____

=====

Do you have difficulty sleeping due to pain? yes no

Please describe in your own words any other problems you are having at this time, which you relate to the accident: _____

What can't you do now that you could do before? _____

Anything else you want to report: _____

Activities of Daily Living (AMA Guides, Fifth Edition, Pg. 4, Table 1-2)

PLEASE CHECK THE APPROPRIATE BOX PER INQUIRY.

| | CATEGORY OF ACTIVITY | ACTIVITY | WITHOUT DIFFICULTY | WITH SOME DIFFICULTY | WITH MUCH DIFFICULTY | MOSTLY UNABLE TO DO |
|-----------------|--|--------------------------|--------------------|----------------------|----------------------|---------------------|
| 1. | SELF-CARE, PERSONAL HYGIENE | Take a shower | | | | |
| | | Take a bath | | | | |
| | (BATHING, BRUSHING TEETH, COMBING HAIR, DRESSING ONESELF, EATING, URINATING, DEFECATING) | Wash & dry face | | | | |
| | | Wash & dry body | | | | |
| | | Turn on/off faucets | | | | |
| | | Brush teeth | | | | |
| | | Comb/brush hair | | | | |
| | | Dress self | | | | |
| | | Put on/off shoes/socks | | | | |
| | | Open carton of milk | | | | |
| | | Open a jar | | | | |
| | | Make a meal | | | | |
| | | Lift fork/spoon to mouth | | | | |
| | | Lift glass/cup to mouth | | | | |
| | | Get on/off toilet | | | | |
| | | Ability to urinate | | | | |
| | | Ability to defecate | | | | |
| Describe other: | | | | | | |

| | CATEGORY OF ACTIVITY | ACTIVITY | WITHOUT DIFFICULTY | WITH SOME DIFFICULTY | WITH MUCH DIFFICULTY | MOSTLY UNABLE TO DO |
|---|---|--|--------------------|----------------------|----------------------|---------------------|
| 2. | PHYSICAL ACTIVITY | Stand | | | | |
| | | Sit | | | | |
| | (STANDING, SITTING, RECLINING, WALKING, CLIMBING STAIRS, LIFTING) | Recline | | | | |
| | | Rise from a chair | | | | |
| | | Get in/out of bed | | | | |
| | | Climb flight of (10) stairs | | | | |
| | | Work outdoors | | | | |
| | | Light housework | | | | |
| | | Shop/do errands | | | | |
| | | Walk | | | | |
| | | Carry groceries | | | | |
| | | Lift 5 lbs. | | | | |
| | | Lift 10 lbs. | | | | |
| | | Lift 20 lbs. | | | | |
| | | Lift 30 lbs. | | | | |
| | | Care for children or parents | | | | |
| | | Engage in hobbies (music or crafts, etc.) indicate hobby: | | | | |
| | | Describe other: | | | | |
| | 3. | COMMUNICATION (WRITING, TYPING, SEEING, HEARING, SPEAKING) | Write a note | | | |
| Type a message on a computer / keyboard | | | | | | |
| See a television screen | | | | | | |
| Use a telephone | | | | | | |
| Speak clearly | | | | | | |
| Hear clearly | | | | | | |
| Describe other: | | | | | | |

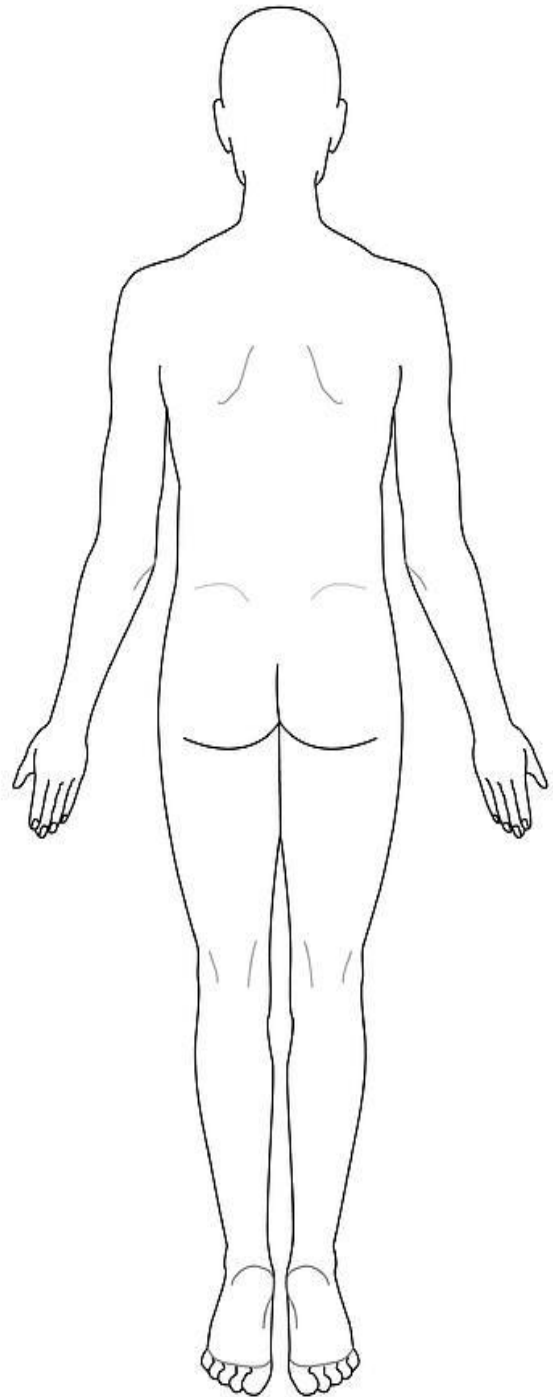
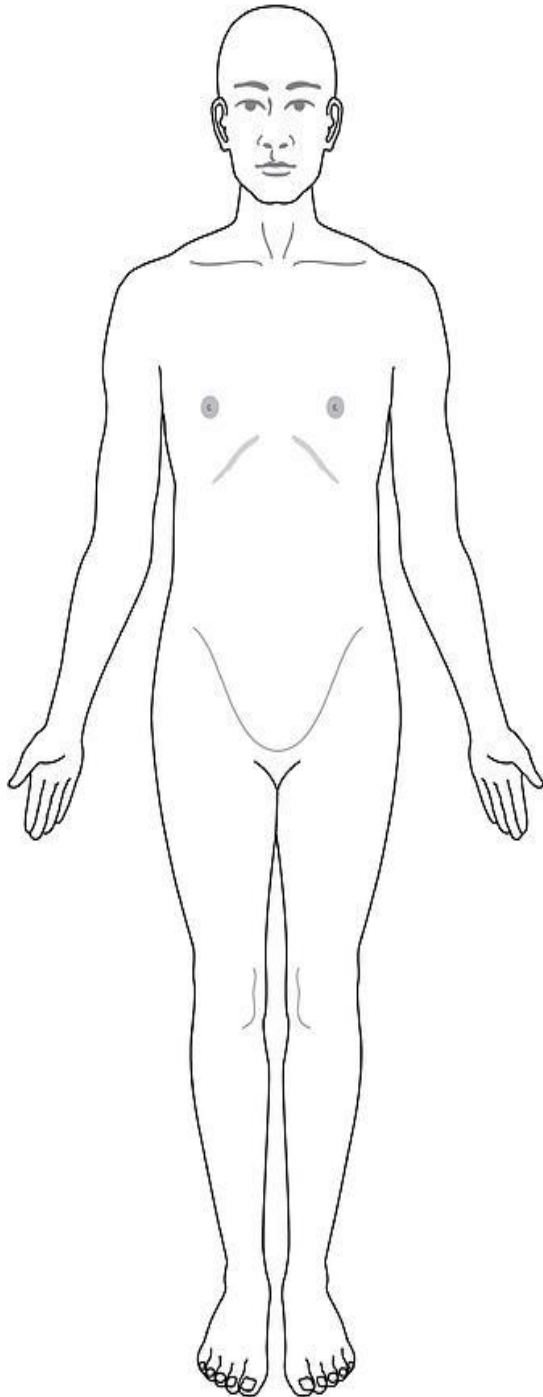
| | CATEGORY OF ACTIVITY | ACTIVITY | WITHOUT DIFFICULTY | WITH SOME DIFFICULTY | WITH MUCH DIFFICULTY | MOSTLY UNABLE TO DO |
|----|--|---------------------------|---------------------------|-----------------------------|-----------------------------|----------------------------|
| 4. | SENSORY FUNCTION (TACTILE FEELING, TASTING, SMELLING) | Feel what you touch | | | | |
| | | Taste what you eat | | | | |
| | | Smell what you eat | | | | |
| | | Describe Other: | | | | |
| 5. | TRAVEL (RIDING, DRIVING, FLYING) | Get in/out of a car | | | | |
| | | Drive a car | | | | |
| | | Ride in a car | | | | |
| | | Ride a bicycle | | | | |
| | | Fly in a plane | | | | |
| | | Describe Other: | | | | |
| 6. | SEXUAL FUNCTION (LUBRICATION, ERECTION, ORGASM, EJACULATION) | Engage in sexual activity | | | | |
| | | Describe Other: | | | | |

Indicate, with the following symbols, the kind of pain and where it is located:

Sharp pain = XXXXX

Dull pain = OOOOO

Numbness & Tingling = //////////////



PAST MEDICAL HISTORY
(per body part)

NECK

Prior to the injury in question, have you ever had similar problems with, or injuries to, the neck involved in this claim? yes no

Was the prior injury work related? yes no

Was the prior injury non-work related? (i.e. auto accidents, slip or falls) yes no

If work related:

Who was your employer at the time? _____

Did you receive treatment? yes no Was a full recovery made? yes no

 If yes, what type of treatment? _____

Was a Workers' Compensation case opened? yes no

 If yes, is it settled? yes no If yes, how much was the settlement? _____

If non-work related:

Please explain what type of injury and date(s): _____

Did you receive treatment? yes no Was a full recovery made? yes no

 If yes, what type of treatment? _____

SHOULDERS

Prior to the injury in question, have you ever had similar problems with, or injuries to, the shoulder(s) involved in this claim? yes no If yes, which shoulder? Right Left

Was the prior injury work related? yes no

Was the prior injury non-work related? (i.e. auto accidents, slip or falls) yes no

If work related:

Who was your employer at the time? _____

Did you receive treatment? yes no Was a full recovery made? yes no

 If yes, what type of treatment? _____

Was a Workers' Compensation case opened? yes no

 If yes, is it settled? yes no If yes, how much was the settlement? _____

If non-work related:

Please explain what type of injury and date(s): _____

Did you receive treatment? yes no Was a full recovery made? yes no

If yes, what type of treatment? _____

ELBOWS

Prior to the injury in question, have you ever had similar problems with, or injuries to, the elbow(s) involved in this claim? yes no If yes, which elbow? Right Left

Was the prior injury work related? yes no

Was the prior injury non-work related? (i.e. auto accidents, slip or falls) yes no

If work related:

Who was your employer at the time? _____

Did you receive treatment? yes no Was a full recovery made? yes no

If yes, what type of treatment? _____

Was a Workers' Compensation case opened? yes no

If yes, is it settled? yes no If yes, how much was the settlement? _____

If non-work related:

Please explain what type of injury and date(s): _____

Did you receive treatment? yes no Was a full recovery made? yes no

If yes, what type of treatment? _____

WRIST/HAND

Prior to the injury in question, have you ever had similar problems with, or injuries to, the wrist or hand(s) involved in this claim? yes no If yes, which wrist/hand? Right Left

Was the prior injury work related? yes no

Was the prior injury non-work related? (i.e. auto accidents, slip or falls) yes no

If work related:

Who was your employer at the time? _____

Did you receive treatment? yes no Was a full recovery made? yes no

If yes, what type of treatment? _____

Was a Workers' Compensation case opened? yes no

If yes, is it settled? yes no If yes, how much was the settlement? _____

If non-work related:

Please explain what type of injury and date(s): _____

Did you receive treatment? yes no Was a full recovery made? yes no

If yes, what type of treatment? _____

HIPS

Prior to the injury in question, have you ever had similar problems with, or injuries to, the hip(s) involved in this claim? yes no If yes, which hip? Right Left

Was the prior injury work related? yes no

Was the prior injury non-work related? (i.e. auto accidents, slip or falls) yes no

If work related:

Who was your employer at the time? _____

Did you receive treatment? yes no Was a full recovery made? yes no

 If yes, what type of treatment? _____

Was a Workers' Compensation case opened? yes no

 If yes, is it settled? yes no If yes, how much was the settlement? _____

If non-work related:

Please explain what type of injury and date(s): _____

Did you receive treatment? yes no Was a full recovery made? yes no

 If yes, what type of treatment? _____

BACK

Prior to the injury in question, have you ever had similar problems with, or injuries to, the back involved in this claim? yes no If yes, upper back or lower back? _____

Was the prior injury work related? yes no

Was the prior injury non-work related? (i.e. auto accidents, slip or falls) yes no

If work related:

Who was your employer at the time? _____

Did you receive treatment? yes no Was a full recovery made? yes no

 If yes, what type of treatment? _____

Was a Workers' Compensation case opened? yes no

 If yes, is it settled? yes no If yes, how much was the settlement? _____

If non-work related:

Please explain what type of injury and date(s): _____

Did you receive treatment? yes no Was a full recovery made? yes no

 If yes, what type of treatment? _____

KNEES

Prior to the injury in question, have you ever had similar problems with, or injuries to, the knee(s) involved in this claim? yes no If yes, which knee? Right Left

Was the prior injury work related? yes no

Was the prior injury non-work related? (i.e. auto accidents, slip or falls) yes no

If work related:

Who was your employer at the time? _____

Did you receive treatment? yes no Was a full recovery made? yes no

 If yes, what type of treatment? _____

Was a Workers' Compensation case opened? yes no

 If yes, is it settled? yes no If yes, how much was the settlement? _____

If non-work related:

Please explain what type of injury and date(s): _____

Did you receive treatment? yes no Was a full recovery made? yes no

 If yes, what type of treatment? _____

ANKLE/FEET

Prior to the injury in question, have you ever had similar problems with, or injuries to, the ankle or feet involved in this claim? yes no If yes, Right Left

Was the prior injury work related? yes no

Was the prior injury non-work related? (i.e. auto accidents, slip or falls) yes no

If work related:

Who was your employer at the time? _____

Did you receive treatment? yes no Was a full recovery made? yes no

 If yes, what type of treatment? _____

Was a Workers' Compensation case opened? yes no

 If yes, is it settled? yes no If yes, how much was the settlement? _____

If non-work related:

Please explain. Was it a fracture, sprain? _____

Did you receive treatment? yes no Was a full recovery made? yes no

 If yes, what type of treatment? _____

MEDICAL HISTORY

Do you have any medical problems or serious illnesses you are being treated for (i.e. diabetes mellitus, high blood pressure, asthma, cancer, high cholesterol, etc)? _____

What medications are you currently taking, or have recently taken? (Over-the-counter and/or prescription) _____

Have you had any surgeries? If so, please describe: _____

Have you been hospitalized for any treatment? If so, please describe: _____

Do you have any allergies to medication? yes no If yes, list: _____

Check below if you have had any of the following diseases/illnesses as a child or as an adult:

| | | | | | | | |
|------------------------------|--|-----------------|--|------------------|--|---------------------|--|
| Anemia | | Diabetes | | Kidney Disease | | Epilepsy/Seizures | |
| Asthma | | Pneumonia | | Fracture | | Hepatitis/Jaundice | |
| Cancer | | Chicken Pox | | Tuberculosis | | High Blood Pressure | |
| Hernia | | Skin Problems | | Rheumatic Fever | | Gallbladder | |
| Polio | | Stool Disorders | | Thyroid Disorder | | Bleeding Disorder | |
| Ulcer | | Mental Disorder | | Arthritis | | Other | |
| Sexually Transmitted Disease | | | | Heart Disease | | Describe: | |

PATIENT PROFILE

Marital Status: Married Single Separated Divorced Widowed

Number of children _____ Age range _____ Do they live with you? yes no

Years of education completed: _____ College Degree(s) _____

Special Training _____

Did you serve in the U.S. Military? yes no If yes, what branch? _____

Dates _____

Do you smoke cigarettes? yes no If yes, how much? _____

Do you drink alcoholic beverages? yes no If yes, how often? _____

Do you use any street/illegal drugs? yes no Comment: _____

Do you have any history of drug or alcohol habit, dependency or abuse? yes no

Comment: _____

Do you have any hobbies, special skills, or interests? yes no If yes, describe: _____

Do you participate in a fitness program or any sports activities? yes no If yes, describe:

Has the injury in question hindered or stopped you from doing any of your usual activities? yes no

If yes, please explain your reasons why: _____

SYSTEMS REVIEW

Circle below if you have any of the following problems:

| <u>Heart/Circulation</u> | <u>Bones/Joints</u> | <u>Stomach/Abdomen</u> | <u>Urogenital</u> |
|--------------------------|--------------------------------|------------------------|---------------------|
| High Blood Pressure | Joint Pain | Nausea/Vomiting | Blood in Urine |
| Chest Pain | Joint Swelling | Peptic Ulcer Disease | Frequency/Urgency |
| Heart Attack | Stiffness | Pain | Getting up at Night |
| Swollen Feet | | Sudden Weight Loss | Discharge |
| Poor Healing | | Change in Bowel Habits | |
| | | Hernia | |
| <u>Neurological</u> | <u>Gynecological</u> | | |
| Numbness/Tingling | Pelvic Pain | | |
| Headaches | | | |
| Coordination Problems | <u>Emotional/Psychological</u> | | <u>Other:</u> |
| Double Vision | Depression | Thoughts of Suicide | |
| Memory Loss | Anger | Loss of Appetite | |
| | Anxiety | Unusual stress | |

PATIENT STATEMENT

The information given in this history questionnaire was provided by me or () through an interpreter, and is true.

Patient's Signature: _____

Printed Name: _____

Date: _____

Interpreter: _____ Agency: _____