Impairment Rating Patient Questionnaire

Doctor John Alchemy, MD

Instructions: This document is necessary for the doctor to write the medical report on your injury claim. Please fill out each question to the best of your ability. This information will insure an accurate reflection of your ongoing problems in the report, in addition to expediting your visit in the office. The information provided in this document is confidential as is your medical chart, and will be filed in your medical chart.

Name:

Today's Date:

Date of Injury:

Date of Birth:

Social Security #:

Your Contact Phone Number:

Your Job Title at time of injury:

Your Employer at time of injury:

Number of Months or Years Employed by Your Employer at time of Injury:

Description of how your injury occurred:

Current Problems (fill out for *each* body location involved in this injury):

1)Body Location:
Pain Quality: (circle one) Ache, Burning, Stabbing, Electrical, Throbbing
Pain Intensity: (one 0=no pain; 10 most severe pain)
Pain Frequency: (circle one) Occasional (25%) Intermittent (50%) Frequent (75%) Constant (100%)
Makes Pain Better: (example-rest, ice, stretching)
Makes Pain Worse: (example-standing, lifting, twisting)
Current Medications for Pain:

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2)Body Location:
Pain Quality: (circle one) Ache, Burning, Stabbing, Electrical, Throbbing
Pain Intensity: (one 0=no pain; 10 most severe pain)
Pain Frequency: (circle one) Occasional (25%) Intermittent (50%) Frequent (75%) Constant (100%)
Makes Pain Better: (example-rest, ice, stretching)
Makes Pain Worse: (example-standing, lifting, twisting)
Current Medications for Pain:

3)Body Location:
Pain Quality: (circle one) Ache, Burning, Stabbing, Electrical, Throbbing
Pain Intensity: (one 0=no pain; 10 most severe pain)
Pain Frequency: (circle one) Occasional (25%) Intermittent (50%) Frequent (75%) Constant (100%)
Makes Pain Better: (example-rest, ice, stretching)
Makes Pain Worse: (example-standing, lifting, twisting)
Current Medications for Pain:

Number of physical therapy visits to date on this injury:

Splints or Supportive Devices used as result of this injury:

Imaging/Special Testing (X-rays, MRI, Nerve Tests - date and body location etc):
1)
2)
3)

Any Surgeries Related to this Injury (Name of Surgery, Date, Location and Surgeon):
1)
2)
3)

Outside Doctors you have seen for this condition, when, and where:
1)
2)
3)

Prior *Similar* Injuries (Date, Body Location and any permanent problems that resulted)
1)
2)
3)

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<u>Activities of Daily Living:</u> Describe how, if at all, your injury interferes with the listed activities below. Please note if there is only pain, or if you CANNOT PERFOMRM THE ACTIVITY AT ALL.

Self-care, personal hygiene: Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating:

Communication: Writing, typing, seeing, hearing, speaking:

Physical activity: Standing, sitting, reclining, walking, climbing stairs:

Sensory function: Hearing, seeing, tactile feeling, tasting, smelling:

Non-specialized hand activities: Grasping, lifting, tactile discrimination:

Travel: Riding, driving, flying:

Sexual functioning: Orgasm, ejaculation, lubrication, erection

Sleep: Restful, nocturnal sleep patterns:

<u>Current Work Status</u> (Full or Modified, comment on any modifications):

<u>General Health Conditions/Past Medical History:</u>

Prior illness:

Prior surgery:

Current (all) medications

Known allergies:

<u>Family History:</u> Do any of the following family members have illness? If yes please state.

Father:

Mother:

Siblings:

Children:

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Social History:

Marital status/ living arrangements:

Employment Status:

Occupation history:

Use of drugs, alcohol, tobacco:

Level of education:

Other relevant social factors: Non-contributory

General Review of Your Present Health: Do you have any CURRENT problems or symptoms with the following? If yes please explain:

Constitutional (Weight changes, fever, fatigue):

Eyes/vision:

Ears, nose or throat:

Cardiovascular, heart or circulation:

Respiratory/breathing:

Gastrointestinal/digestive:

Genitourinary/Urinary or reproductive:

Musculoskeletal/joints:

Skin:

Neurological/dizziness/weakness/sensory:

Psychiatric/depression/anxiety/history of suicidal thoughts/addictions:

Endocrine/diabetes or thyroid:

Hematological/lymphatic/bruising/bleeding or swollen areas:

allergic/immunologic, drug intolerance etc:

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