Southern Pain and Rehab, LLC **Michael J. Kohrman MD** www.southernpainandrehab.com
Board Certified Physical Medicine & Rehabilitation, Board Certified Pain Medicine
EMG/NCV's, IME's, Interventional Pain, Non-Surgical Spine, Sport, Shoulders, Hips, Knees & more
Hours by Appointment
Thomas Medical Center 27961 US Highway 98, Suite 11-A Daphne, AL 36526 Phone: 251-626-0901 Fax: 251-626-0902

INDEPENDENT MEDICAL EXAMINATION INFORMATION

To the best of my knowledge I have never been treated as a patient of Michael J Kohrman MD

_____ _____
Signature Date

_____
Printed or Typed Name

I understand that I am here for an Independent Medical Evaluation, a Second Opion, or an Impairment Evaluation; this means the doctor performing the evaluation is neither treating me nor an employee of whomever requested the evaluation. There is no doctor patient relationship established. The doctor is not an employee of any insurance company, third party administrator, attorneys, governmental agency, employer, or physician that has requested the evaluation. The purpose of the evaluation is to provide a thorough objective evaluation of the specific condition-s related to the injury or illness in question. It includes prior or subsequent conditions that may affect it, and answer whatever questions the requesting party has. This document outlines the IME process, my rights, and my responsibilities.

This IME or evaluation is not a comprehensive medical evaluation. It will not provide advice or treatment or substitute for evaluation or treatment by my regular treating doctor. A physician-patient relationship is not established between the evaluating physician and me. Accordingly, there is no patient-physician privilege associated with this evaluation. Usually a written report will be provided summarizing today's evaluation and will be sent back to the requesting organization or party. If I would like a copy of the report or have further questions, I will contact them and not the evaluating physician.

I understand that generally my evaluation will begin with intake forms and questions from a staff member, the doctor asking me further questions regarding my problems-s, how it began, and what evaluations and treatments have been done accordingly. Information I personal provide along with additional medical records available will be used for the review. The doctor will then ask about other information such as my work status, etc. All information I provide will also be in the report.

After the interview, a physical examination of the relevant body part-s will be conducted. I fully understand that I need to tell the doctor in advance about performing a maneuver that I feel I may not be able to do safely. I understand I am not required to do anything that I feel may worsen or cause any harm to me. If, at any time, anything is causing me discomfort I will inform the doctor so it can be stopped immediately. I understand there may be some mild discomfort, pain, stiffness or other symptoms produced in most examinations of this sort. Touching a tender spot or checking how far I can comfortably move a stiff joint are a couple examples. Such findings are helpful in understanding my condition. The IME or evaluation, however, is not intended to cause any injury or excessive pain. I understand that in order to avoid that, I must fulfill my responsibility to inform the doctor-s if there is something I am concerned that I can not do or if something may cause too much discomfort. Etc.

I understand that I am permitted to have a Chaperone present during the examination, at my request.

I consent to the taking of photographs to document findings during the physical examination.

I have read and understand the information above and it's instructions. I authorize this physician or any co-worker to obtain any information that may be relevant to the condition-s in question. I agree to have this information and results of the IME or evaluation, verbally or in writing to the entity or it's representatives that has requested the IME or evaluation.

_____ _____
Signature Date

_____
Printed or Typed Name

PATIENT INFORMATION

First Name: _____ Middle _____

Last Name: _____ Title _____

Address: _____

Zip Code: ☐☐☐☐☐ ☐☐☐☐ City: _____ State : _____

Home Phone: ☐☐☐ ☐☐☐ ☐☐☐☐ Cell Phone #: ☐☐☐ ☐☐☐ ☐☐☐☐

Office Phone: ☐☐☐ ☐☐☐ ☐☐☐☐ Contact #: ☐☐☐ ☐☐☐ ☐☐☐☐

SSN #: ☐☐☐ ☐☐ ☐☐☐☐ Date of Birth: Month ☐☐ Day ☐☐☐☐ Yr

Marital Status ☐ Single ☐ Married ☐ Partner ☐ Significant Other ☐ Separated ☐ Divorced ☐ Widowed

Insurance: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Self Pay ☐ Worker's Comp ☐ MVA ☐ Personal Injury

Referred By: ☐ Physician _____ ☐ Self ☐ OR _____

Have you seen Dr. Kohrman before? ☐ Yes ☐ No ☐ When ? _____

Family Physician: _____ Where : _____

Employer: _____ Employed how long? _____

Address: _____

Zip Code: ☐☐☐☐☐ ☐☐☐☐ City: _____ State : _____

Primary Insurance: ☐ **Commercial** ☐ **Medicare** ☐ **Medicaid** ☐ **Self Pay** ☐ **Worker's Comp** ☐ **MVA**

Carrier Name: _____ Effective Date: ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

Subscriber's Last Name: _____ Middle _____

Subscriber's First Name: _____ Title _____

Relationship: ☐ Self ☐ Spouse Subscriber's Date of Birth ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

Address: _____

Zip Code: ☐☐☐☐☐ ☐☐☐☐ City: _____ State : _____

Home Phone: ☐☐☐ ☐☐☐ ☐☐☐☐ Cell Phone #: ☐☐☐ ☐☐☐ ☐☐☐☐

Office Phone: ☐☐☐ ☐☐☐ ☐☐☐☐ Contact #: ☐☐☐ ☐☐☐ ☐☐☐☐

Subscriber's SSN #: ☐☐☐ ☐☐ ☐☐☐☐ Subscriber's Sex ☐ Male ☐ Female

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Secondary Insurance: ☐ **Commercial** ☐ **Medicare** ☐ **Medicaid** ☐ **Self Pay** ☐ **Worker's Comp** ☐ **MVA**

Carrier Name: _____ Effective Date: ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

Subscriber's Last Name: _____ Middle _____

Subscriber's First Name: _____ Title _____

Relationship: ☐ Self ☐ Spouse Subscriber's Date of Birth ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

Address: _____

Zip Code: ☐☐☐☐☐ ☐☐☐☐ City: _____ State : _____

Home Phone: ☐☐☐ ☐☐☐ ☐☐☐☐ Cell Phone #: ☐☐☐ ☐☐☐ ☐☐☐☐

Office Phone: ☐☐☐ ☐☐☐ ☐☐☐☐ Contact #: ☐☐☐ ☐☐☐ ☐☐☐☐

Subscriber's SSN #: ☐☐☐ ☐☐ ☐☐☐☐ Subscriber's Sex ☐ Male ☐ Female

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WHAT PHARMACY DO YOU GO TO?

Name: _____

Address: _____

Zip Code: ☐☐☐☐☐ ☐☐☐☐ City: _____ State : _____

Phone #: ☐☐☐ ☐☐☐ ☐☐☐☐ Fax #: ☐☐☐ ☐☐☐ ☐☐☐☐

WHAT MAIL-IN PHARMACY DO YOU GO USE? Do they have a 90 day supply? ☐ Yes ☐ No ☐ Maybe

Name: _____

Address: _____

Zip Code: ☐☐☐☐☐ ☐☐☐☐ City: _____ State : _____

Phone #: ☐☐☐ ☐☐☐ ☐☐☐☐ Fax #: ☐☐☐ ☐☐☐ ☐☐☐☐

AUTHORIZATION & ASSIGNMENT

Unless you have provided insurance information, you are responsible for payment of services when rendered.
Patients who carry Medical / Surgical Insurance should remember that Professional Services (Physician's Fees) are charges to You (or the patient) and not to the Insurance Company. Each Insurance Company has it's own policy or policies concerning payment of services. Some pay fixed allowances for certain procedures and others pay a percentage of the charge. There are no standard Usual Customary and Reasonable (UCR) charges that all of the Insurance Companies follow. It is your responsibility to know what your policy covers. *It is your responsibility to pay any deductible amount, co-pay amount, or any other balance not paid for by your Insurance Policy / Company.*

If this amount is assigned to a Collection Agency and / or it's Attorney for collection and / or suit, Southern Pain and Rehab, LLC / Dr. Kohrman shall be entitled to reasonable fees and the cost of collection.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as the original.

ALL PATIENTS (COMMERCIAL INSURANCE, MEDICAID, MEDIGAP, WORKER'S COMP, MVA)

I request that payment of authorized Insurance Benefits be made either to me or on by behalf to Southern Pain and Rehab, LLC /Dr. Kohrman for any services furnished to me by that physician.
I authorize release to my Insurance Company and it's agents any medical information about me needed to determine the payments for related services.

Signature: _____ **Date** ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

First Name: _____ **Last Name:** _____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare Benefits be made either to me or on by behalf to Southern Pain and Rehab, LLC / Dr. Kohrman for any services furnished to me by that physician.
I authorize release to the Centers for Medicare and Medicaid Services and it's agents any medical information about me needed to determine the payments for related services.

Signature: _____ **Date** ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

First Name: _____ **Last Name:** _____

AKNOWLEDGEMENT OF NOTICE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Signature: _____ **Date** ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

First Name: _____ **Last Name:** _____

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Name _____ _____ **SSN #** _____ **Date** _____

New Accident or Injury Form

Condition? ☐ MVA ☐ Work Related ☐ Personal Injury **Onset?** ☐ Sudden ☐ Gradual ☐ Trauma ☐ No Trauma

Problem Onset Date ☐☐ Day ☐☐ Month ☐☐☐☐ Yr ☐ Exactly ☐ About **Your Age was** ☐☐☐

Your job at the time _____ **Employed how long** ☐☐ Days ☐☐ Months ☐☐ Yrs

Claim OK'ed Yes ☐ No ☐ Not sure **It's Pending** Yes ☐ No ☐ Not sure **Any Litigation** Yes ☐ No ☐ Not sure

Any Alcohol Yes ☐ No ☐ Not sure **Any Drugs** Yes ☐ No ☐ Not sure **Any Violence** Yes ☐ No ☐ Not sure

What were you doing when you got injured _____

When the injury happened you were? ☐ Sleeping ☐ Groggy ☐ Drunk ☐ Sober ☐ Awake ☐ Alert

What happened _____

_____

_____

You were ☐ Without safety equipment ☐ Wearing Seat Belt ☐ 2 point ☐ 3 point ☐ 4 point ☐ Helmet

☐ Other safety gear you were using was _____

Were you cited ☐ No ☐ Yes **Were you at fault** ☐ No ☐ Yes **Was anyone at fault** ☐ No ☐ Yes

Were you dazed ☐ No ☐ Yes **Were you knocked out** ☐ No ☐ Yes **How long** _____

Do you remember the accident ☐ No ☐ Yes **Before the accident** ☐ No ☐ Yes **After the accident** ☐ No ☐ Yes

Was the accident witnessed ☐ No ☐ Yes **Police were there** ☐ No ☐ Yes **Paramedics were there** ☐ No ☐ Yes

How soon after were you treated ☐ Right away ☐ Same Day ☐☐ Days ☐☐ Weeks ☐☐ Months later

Who treated you first _____ ☐ Same Day ☐☐ Days ☐☐ Weeks ☐☐ Months later

You went to a hospital ER ☐ Not Seen ☐ Same Day ☐☐ Days ☐☐ Weeks ☐☐ Months later

How long were you in a hospital ☐ Not Admitted **Hospitalized** ☐☐ Days ☐☐ Weeks ☐☐ Months

Were you seen by a specialist ☐ Not Seen ☐ Same Day ☐☐ Days ☐☐ Weeks ☐☐ Months later

Your Injuries were _____

_____

Tests that were done _____

_____

Surgeries done were _____

Doctors you saw _____

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Name _____ _____ **SSN #** _____ **Date** _____

Last Surgery / Operation / Procedure done for the Main Problem you are being seen for?

Condition? ☐ MVA ☐ Work Related ☐ Personal Injury **Onset?** ☐ Sudden ☐ Gradual ☐ Trauma ☐ No Trauma

In the past how many Motor Vehicle Accidents ? ☐☐ **Who was at Fault ?** ☐ Self ☐ Other ☐ Both ☐ No one

In the past how many Work Related Injuries ? ☐☐ **Who was at Fault ?** ☐ Self ☐ Other ☐ Both ☐ No one

In the past how many Personal Injuries ? ☐☐ **Who was at Fault ?** ☐ Self ☐ Other ☐ Both ☐ No one

Last Procedure / Surgery was _____

Where was it done _____

Procedure Date ☐☐ Day ☐☐ Month ☐☐☐☐ Yr **Physician** _____

Problems started ☐ Exactly ☐ About ☐☐ Day ☐☐ Month ☐☐☐☐ Yr **Your age was** ☐☐☐

Main Problems Before Procedure? ☐ Pain ☐ Weakness ☐ Numbness ☐ Incoordination ☐ Bowel ☐ Bladder

☐ **Other** _____

Main Problems After Procedure? ☐ Pain ☐ Weakness ☐ Numbness ☐ Incoordination ☐ Bowel ☐ Bladder

☐ **Other** _____

What was better after Procedure? ☐ Pain ☐ Weakness ☐ Numbness ☐ Incoordination ☐ Bowel ☐ Bladder

☐ **Other** _____

What was worse after Procedure? ☐ Pain ☐ Weakness ☐ Numbness ☐ Incoordination ☐ Bowel ☐ Bladder

☐ **Other** _____

Overall you are doing? ☐ Back to Normal ☐ Better ☐ About the same ☐ Making NO real progress ☐ Getting worse

☐ **Other** _____

What problems did you have before the problem started?

What problems did you have after the problem started?

What Surgeries / Procedures were done for this problem?

What do you realistically want done?

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Name _____ **Last** _____ **SSN #** _____ **Date** _____

Intake Forms. Please fill out the form the best you can

ID # | | | | | | | | | | | | | | | | | |

AGE | | | Years **RACE** _____ ☐ Male ☐ Female **HANDED** ☐ Right ☐ Left ☐ Both

Height | | ft | | | inches Weight | | | pounds BP | | | / | | | Pulse | | |

Today's visit is for an? ☐ Initial Eval ☐ Follow Up ☐ IME ***Condition?*** ☐ MVA ☐ Work Related ☐ Personal Injury

Who sent you here _____ What Doctors do you see _____

Who is Your PCP _____ What Doctors do you see _____

Your Attorney is _____ What Doctors do you see _____

Litigation is ☐ NOT an Issue ☐ Pending ***Main Problem*** _____

Chief Complaint? ☐ **Pain** ☐ **Weakness** ☐ **Numbness** ☐ **Burning** ☐ **Tingling** ☐ **Pins & Needles** ☐ **OTHER**

#____ Complaint? _____

#____ Complaint? _____

Overall you are doing? ☐ Back to Normal ☐ Better ☐ About the same ☐ Making NO real progress ☐ Getting worse

This is a ☐ New problem ☐ Old problem ☐ Both an old and new problem being treated ☐ Aggravation of an old problem

Onset Date ? ☐ Exactly ☐ Around | | Month | | Day | | | | | Yr Your Age then was | | |

What Happened? _____

_____

_____

_____

HAD Recent ☐ X-Rays ☐ MRI's ☐ CT Scan's ☐ Bone Scan's ☐ EMG/NCV's ☐ Blood Tests ☐ Sleep Study

☐ Other _____

Results ☐ Not Known OR _____

Results _____

HAD Recent ☐ PT ☐ OT ☐ Speech ☐ Massage ☐ Manipulation ☐ TENS ☐ Brace ☐ Meds Change ☐ Procedure

Results ☐ Not Sure ☐ Helped some ☐ Better ☐ Back to Previous State ☐ Back to Normal ☐ Did not help ☐ Worse

HAD Recent ☐ ER Visit ☐ Urgi-Care ☐ Hospital Admissions ☐ Operation-s ☐ Other Doctor's Visit ☐ Case Hearing

When | | Month | | Day | | | | | Yr **Why** _____

Results ☐ Not Known OR _____

Your Current Work Status is? ☐ Working & NO Restrictions ☐ Working with Restrictions ☐ Not Working ☐ Retired

Last Worked | | Month | | Day | | | | | Yr ☐ On Worker's Comp ☐ Off due to Personal Injury

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Name _____ **Last** _____ **SSN #** _____ **Date** _____

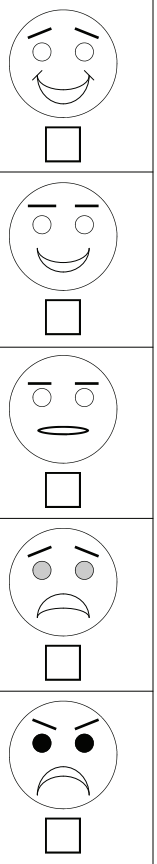
PAIN DRAWING DIAGRAM

Overall you are doing? ☐ Back to Normal ☐ Better ☐ About the same ☐ Making NO real progress ☐ Getting worse

ANY WEAKNESS?
☐ NO ☐ YES

IS IT NEW?
☐ NO ☐ YES

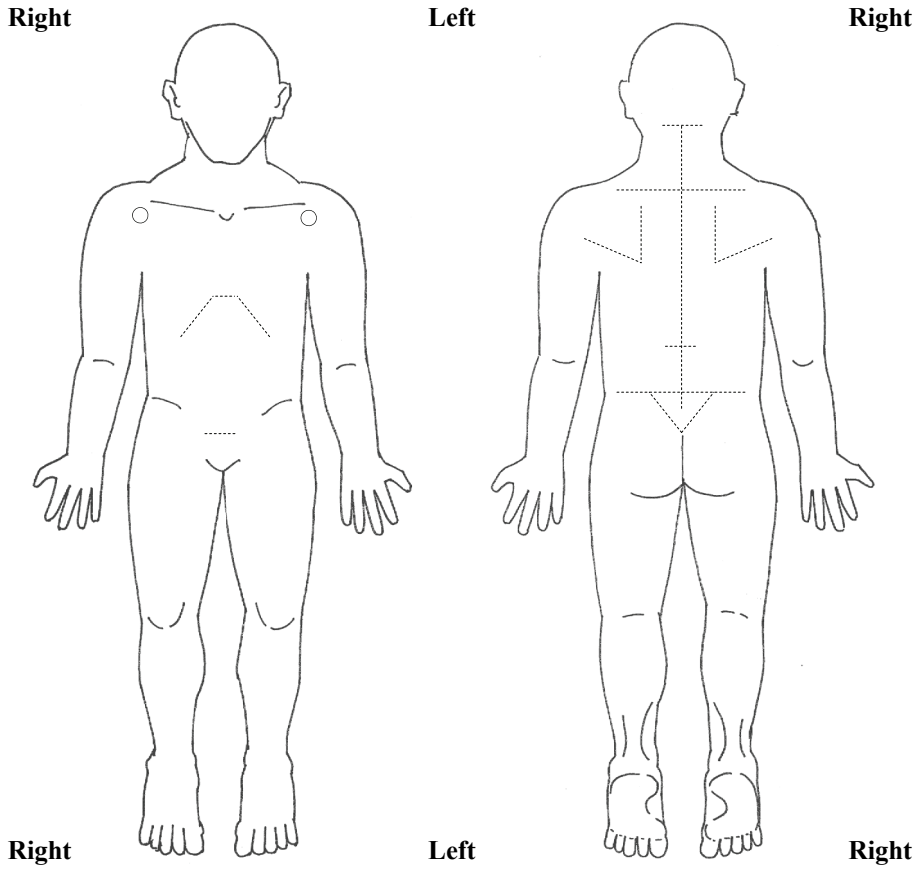
Mark the box Below the face that looks like YOU Most of the time



WHAT IS WEAK ?	**What Side ? Right**	**Left**
Head / Neck	☐	☐
Upper Back	☐	☐
Trunk	☐	☐
Low Back	☐	☐
Shoulder	☐	☐
Arm	☐	☐
Forearm	☐	☐
Wrist	☐	☐
Hand	☐	☐
Hip	☐	☐
Upper Leg	☐	☐
Lower Leg	☐	☐
Ankle	☐	☐
Foot	☐	☐

WHERE IS YOUR PAIN NOW?
Use the following symbols to mark where you have pain on the body below.

Aching	**Numbness**	**Pins / Needles**	**Burning**	**Stabbing**	**Other**
△△△	＝＝＝	OOO	XXX	///	●●●



What Problems are you Currently Having? Mark all that apply.

☐ Poor Coordination	☐ Mental Trouble	☐ Emotions	☐ Always Tired	☐ Sex Concerns	☐ Personal Issues
☐ Balance Problems	☐ Listening	☐ Mood Swings	☐ Poor Energy	☐ Do Not Care	☐ Tobacco User
☐ Vertigo / Dizziness	☐ Speaking	☐ Anxious	☐ Can Not Sleep	☐ No Desire	☐ Nicotine User
☐ Trouble Walking	☐ Memory	☐ Agitation	☐ Falling Asleep	☐ Physical Issues	☐ Caffeine User
☐ Poor Bowel Control	☐ Thinking	☐ Anger Outbursts	☐ Trouble Sleeping	☐ Impotency	☐ Alcohol User
☐ Bowel Accidents	☐ Confusion	☐ Withdrawn	☐ Snores a Lot	☐ Pain with Sex	☐ Drug Abuse
☐ Bad Bladder Control	☐ Problem Solving	☐ Depressed	☐ Takes Naps	☐ Sexual Abuse	☐ Alcohol Abuse
☐ Bladder Accidents	☐ Poor Judgment	☐ Suicide Thoughts	☐ Sleep Apnea	☐ Physical Abuse	☐ Legal Problems

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Do you have PAIN? ☐ NO ☐ YES ***How would you describe your PAIN? Please fill in ALL that applies.***

Pain Quality is	**Pain Quality is**	**Pain Intensity is**	**Pain Duration is**	**Pain Timing is**	**Your Sleep is**
☐ Throbbing	☐ Aching Heavy	☐ No Pain	☐ Seconds	☐ Rarely	☐ OK to Good
☐ Shooting	☐ Tender	☐ Mild	☐ Minutes	☐ Occasionally	☐ Poor to Bad
☐ Stabbing	☐ Splitting	☐ Moderate	☐ Hours	☐ Sometimes	☐ Snores & Naps
☐ Sharp	☐ Exhausting	☐ Severe	☐ Always	☐ A lot	☐ Falls Asleep
☐ Cramping	☐ Sickening	☐ Distressing	☐ All Day	☐ Always	**Your Mood is**
☐ Gnawing	☐ Fearful	☐ Horrible	☐ All Night	☐ With Activity	☐ OK to Good
☐ Hot Burning	☐ Punishing Cruel	☐ Excruciating	☐ Varies a lot	☐ With Rest	☐ Poor to Bad

From the group below what Descriptions BEST describes you and your current situation?

☐	☐	☐	☐	☐
Asymptomatic Or Intermittent Symptoms	Symptoms with Strenuous Activity Able to do Self-Care Independently	Symptoms with Normal Activity; Able to do Self-Care with Moderate Help but Unassisted	Symptoms with Less than Normal Activity Requires Some Help to do Self Care	Symptoms at Rest Not Able to do Self Care Needs Significant Help to do Self Care

Do you need anyone to help you? ☐ NO ☐ YES WHO ? _____

What do they do for you? _____

IF we count " your worst pain ever " as a number " 10 " and then No Pain as " 0 " What is your current pain level? ☐☐

A GOOD Day your pain level is about ? ☐☐ On a BAD Day it is? ☐☐ Overall your pain level is? ☐☐

Are you taking Pain Medication now? ☐ NO ☐ YES Did you before this problem started? ☐ NO ☐ YES

Do you use a TENS ? ☐ NO ☐ YES Do you use FES? ☐ NO ☐ YES Does it help? ☐ NO ☐ YES

What Aggravates your Overall Problem-s?

☐ Nothing	☐ Standing	☐ Bathing	☐ Working
☐ Rest	☐ Bending	☐ Shower	☐ Heat
☐ Sitting	☐ Twisting	☐ Dressing	☐ Cold
☐ Laying Down	☐ Reaching	☐ Dishes	☐ Therapy
☐ On Side	☐ Lifting	☐ Housework	☐ Massage
☐ On Back	☐ Climbing	☐ Driving	☐ Meds
☐ On Stomach	☐ Walking	☐ Sports	☐ TENS
☐ Knees Bent	☐ Jogging	☐ Family	☐ E Stim
☐ Legs Up	☐ Running	☐ Friends	☐ Injections
☐ Legs Down	☐ Crawling	☐ Co-workers	☐ Surgery

☐ **OTHER** _____

What Helps your Overall Problem-s?

☐ Nothing	☐ Standing	☐ Bathing	☐ Working
☐ Rest	☐ Bending	☐ Shower	☐ Heat
☐ Sitting	☐ Twisting	☐ Dressing	☐ Cold
☐ Laying Down	☐ Reaching	☐ Dishes	☐ Therapy
☐ On Side	☐ Lifting	☐ Housework	☐ Massage
☐ On Back	☐ Climbing	☐ Driving	☐ Meds
☐ On Stomach	☐ Walking	☐ Sports	☐ TENS
☐ Knees Bent	☐ Jogging	☐ Family	☐ E Stim
☐ Legs Up	☐ Running	☐ Friends	☐ Injections
☐ Legs Down	☐ Crawling	☐ Co-workers	☐ Surgery

☐ **OTHER** _____

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Name _____ **Last** _____ **SSN #** _____ **Date** _____

Has there been a significant change in your health recently? ☐ NO ☐ YES ***Any recent procedure or hospital visit?*** ☐ NO ☐ YES

What ? _____

Review of Symptoms & Systems Mark ALL that Applies to you recently

General	☐ Fever	☐ Chills	☐ Night Sweats	☐ Fatigue	☐ Weight Gain	☐ Weight Loss
HEENT	☐ New Headache	☐ Vision Change	☐ Hearing Change	☐ Balance Change	☐ Sinus Problems	☐ Sore Throat
HEENT	☐ Confusion	☐ Memory Issues	☐ Black Outs	☐ Troubled Speech	☐ Can't Swallow	☐ New Weakness
Neurologic	☐ Dizziness	☐ Balance Issues	☐ Trouble Walking	☐ Weakness	☐ Coordination	☐ Dropping Things
Muscular	☐ Weakness	☐ Trigger Points	☐ Cramps	☐ Spasms	☐ Bursitis	☐ Tendonitis
Skeletal	☐ Joint Stiffness	☐ Joint Pain	☐ Bone Pain	☐ Trouble Moving	☐ Sprains / Strains	☐ Fractures
Psychiatric	☐ Mood Changes	☐ Anxiety	☐ Panic Problems	☐ Thought Change	☐ Depression	☐ Suicidal
Cardiac	☐ Chest Pain	☐ Chest Pressure	☐ More Sweating	☐ Nausea	☐ Vomiting	☐ New Arm Pain
Respiration	☐ Breath Shortness	☐ New Cough	☐ Chest Pain	☐ Wheezing	☐ Asthma	☐ Need Oxygen
GI System	☐ Bowel Change	☐ Heart Burn	☐ Gas / Bloating	☐ Diarrhea	☐ Constipation	☐ Bloody Stools
GU System	☐ Bladder Change	☐ Flank Groin pain	☐ Urgency	☐ Burning	☐ Incontinence	☐ Bloody Pee
Sex Organs	☐ Sore Breasts	☐ Groin Pain	☐ Discharge	☐ Sex Problems	☐ Erection Issues	☐ Impotency
Skin	☐ Skin Change	☐ Itching	☐ Rash	☐ Old Sores	☐ New Sores	☐ Bruising
Endocrine	☐ Diabetes	☐ Need Insulin	☐ Energy Change	☐ Hair Changes	☐ Fatigue	☐ Low Sex Drive
Immune	☐ Infections	☐ Hepatitis	☐ TB	☐ AIDS / Related	☐ Tumors /Growth	☐ Cancer
Blood	☐ Blood Disorders	☐ Bleeding	☐ Bruising	☐ Clotting	☐ Swelling / Pain	☐ Blood Thinners
Vessels	☐ Warm Limb	☐ Cold Limb	☐ Red Limb	☐ White Limb	☐ Blue Limb	☐ Black Limb

You had	☐ Heart Attacks	☐ Bypass Surgery	☐ Valve Surgery	☐ Heart Stints	☐ Vein Stripping	☐ Vessel Surgery
You have	☐ Pacemaker	☐ Internal Pump	☐ Stimulator	☐ Metal Implants	☐ Metal Staples	☐ Metal Shavings
You are	☐ Pregnant	☐ Claustrophobic	☐ Anxious	☐ Have High BP	☐ Have Low BP	☐ Dizzy
You take	☐ Antibiotics	☐ Anti-virals	☐ Anti-fungals	☐ Cancer Meds	☐ Steroids	☐ Psych Meds
You take	☐ Blood Thinners	☐ Aspirin	☐ NSAIDS	☐ Plavix	☐ Coumadin	☐ Heart Meds
History Of	☐ Tobacco Use	☐ Caffeine Use	☐ Alcohol Abuse	☐ Drug Abuse	☐ Physical Abuse	☐ Sex Abuse
You still use	☐ Tobacco	☐ Caffeine	☐ Soft Drinks	☐ Alcohol	☐ Other's Meds	☐ Illegal Meds

Current Allergies and Sensitivities Anything New? Mark ALL that Applies to you

☐ NONE	☐ Phenol	☐ Glycerin	☐ Cod Liver Oil	☐ Vitamin A	☐ Sarapin	☐ Botox
☐ Lidocaine	☐ Marcaine	☐ Procaine	☐ Sea Food	☐ Shell Fish	☐ IVP Dye	☐ Contrast Dyes
☐ Cholor prep	☐ Iodine	☐ Betadine	☐ Steroids	☐ Latex	☐ Paper Tape	☐ Cloth Tape
☐ Seasonal Stuff	☐ Dogs	☐ Cats	☐ Molds	☐ Yeast	☐ Fungus	☐ Dust
☐ OTHER						

What Sensitivities and Reactions to you get Anything New? Mark ALL that Applies to you

☐ Rapid Heart	☐ Itching	☐ Rash	☐ Swelling	☐ Bruising	☐ Short Breath	☐ Can't Breath
☐ Can't Swallow	☐ Diarrhea	☐ Constipation	☐ Can't Pee	☐ Nausea	☐ Fainting	☐ Need Epi Pen
☐ Mood Swings	☐ Agitation	☐ Out Bursts	☐ Confusion	☐ Depression	☐ Suicidal	☐ Ned ER Visit
☐ OTHER						

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Has there been a significant change in your health recently? ☐ NO ☐ YES ***Any recent procedure or hospital visit?*** ☐ NO ☐ YES

What ? _____

Past Medical History Mark ALL that Applies to you recently

General	☐ Chronic Pain	☐ Chronic Fatigue	☐ Hyper tension	☐ Hypo tension	☐ Sleep Problems	☐ Fibromyalgia
Headaches	☐ New Headache	☐ Migraines	☐ Tension	☐ Cluster	☐ Whiplash	☐ Hormonal
Head Injury	☐ Open Injury	☐ Closed Injury	☐ Concussions	☐ Strokes	☐ TIA's	☐ Tumors
Head	☐ Alzheimer's	☐ Cerebral Palsy	☐ Poor Memory	☐ Poor Attention	☐ Poor Speech	☐ Weakness
Eyes	☐ Blindness	☐ Cataracts	☐ Double Vision	☐ Glaucoma	☐ Poor Vision	☐ Retina Problems
Ears	☐ Balance Issues	☐ Deafness	☐ Dizziness	☐ Ear Ringing	☐ Poor Hearing	☐ Vertigo
Nose	☐ Bloody Nose	☐ Septum Problem	☐ Nasal Polyps	☐ Sinusitis	☐ Snorer	☐ Sleep Apnea
Throat	☐ Poor Speech	☐ High Palate	☐ Poor Swallow	☐ Bad Teeth	☐ TMJ Problems	☐ Dental Work
Cardiac	☐ Heart Attacks	☐ Congested Heart	☐ Valve Disease	☐ Rhythm Issues	☐ Hyper Tension	☐ Hypo Tension
Respiration	☐ Asthma	☐ Bronchitis	☐ COPD	☐ Emphysema	☐ Smoker	☐ Need Oxygen
GI System	☐ Ulcers / Reflux	☐ Liver Disease	☐ Hepatitis	☐ Cirrhosis	☐ Constipation	☐ Diarrhea
	☐ Leaky Gut	☐ High Cholesterol	☐ High Lipids	☐ Gallbladder	☐ Gall Stones	☐ Pancreatitis
	☐ Appendix	☐ Irritable Bowel	☐ Polyps	☐ Diverticulitis	☐ Hemorrhoids	☐ Bloody Stools
GU System	☐ Renal Disease	☐ Bladder Disease	☐ Kidney Stones	☐ Bladder Stones	☐ Incontinence	☐ Infections
Male	☐ Breast Disease	☐ Infections	☐ Testicle Torsion	☐ Prostratitis	☐ Poor Erection	☐ Impotency
Female	☐ Breast Disease	☐ Infections	☐ Ovary Problems	☐ Uterine Issues	☐ Infertility	☐ Menopause
Skin	☐ Rashes	☐ Infections	☐ Scar Tissue	☐ Dry /Oily Skin	☐ Sclerosis	☐ Lots of Sweat
Endocrine	☐ Pituitary Trouble	☐ Thyroid	☐ Estrogen	☐ Progesterone	☐ Testosterone	☐ Vitamin D
Diabetes	☐ Juvenile Onset	☐ Adult Onset	☐ Insulin Needed	☐ Insulin Pump	☐ Meds Controlled	☐ HYPO glycemic
Immune	☐ Infections	☐ Bacterial	☐ Viral	☐ Fungal	☐ Parasites	☐ Tumors
	☐ Hepatitis Active	☐ Hepatitis	☐ STD's	☐ TB	☐ AIDS / Related	☐ Cancer
Blood	☐ Blood Disorder	☐ Anemia	☐ Bleeding	☐ Clotting	☐ DVT / Clots	☐ Blood Thinners
Vessels	☐ Artery Disease	☐ Vein Disease	☐ Vasculitis	☐ Raynaud's	☐ Burger's	☐ Lymph edema
Neurologic	☐ Weakness	☐ Pain	☐ Polyneuropathy	☐ Radiculopathy	☐ Neuritis	☐ Nerve Injuries
Muscular	☐ Weakness	☐ Myocitis	☐ Myopathy	☐ Dystrophies	☐ Dystonia	☐ Atrophy
Skeletal	☐ Osteoarthritis	☐ Osteoporosis	☐ Rheumatoid	☐ Gout	☐ Bursitis	☐ Tendonitis
	☐ Sprains / Strains	☐ Ligament Issues	☐ Tissue Tears	☐ Impingements	☐ Fractures	☐ Compression Fx

Psychiatric	☐ Psychological Disorder	☐ Attention Disorder	☐ Anxiety / Panic Disorder	☐ Claustrophobia
	☐ Depression	☐ Manic Depression	☐ Mood Disorder	☐ Obsessions
	☐ Personality Disorder	☐ Post Traumatic Stress	☐ Schizophrenia	☐ Suicidal Thoughts
	☐ Suicidal Attempts	☐ Thought Disorder	☐ Work Swing Shift	☐ History of Violence
	☐ Alcohol Abuse	☐ Drug Abuse	☐ Physical Abuse	☐ Sexual Abuse

Cancer-s _____ ☐ Radiation Txs ☐ Chemotherapy

OTHER _____

OTHER _____

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What are you able to do? Please MARK the BOX what best describes what you are able to do and if you need help.

Claim Number | | | | | | | | | | | | | | | | | |

Instructions: These questions ask for your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the <u>ONE</u> block on the scale that best describes how you feel.

1 Does your pain interfere with your normal work inside and outside the home?
I work normally ← ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ → I am unable to work at all

2 Does your pain interfere with your personal care (such as washing, dressing, etc.)?
I take care of myself completely ← ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ → Help is needed for all personal care

3 Does your pain interfere with your traveling?
I travel anywhere I like ← ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ → I only travel to see doctors

4 Does your pain affect your ability to sit or stand?
I have no problems ← ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ → I can not sit or stand at all

5 Does your pain affect to lift overhead, grasp objects, or reach for things?
I have no problems ← ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ → I can not do it at all

6 Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
I have no problems ← ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ → I can not do it at all

7 Does your pain affect your ability to walk or run?
I have no problems ← ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ → I can not walk or run at all

8 Has your income declined since your pain began?
There has been no Decline ← ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ → I lost all my income

9 Do you have to take pain medication every day to control your pain?
There is no medication needed ← ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ → I'm on pain meds throughout day

10 Does your pain force you to see doctors much more often than before your pain began?
I never see doctors ← ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ → I see doctors weekly

11 Does your pain interfere with your ability to see people who are important to you as much as you would like?
I have no problems ← ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ → I never see them

12 Does your pain interfere with recreational activities and hobbies that are important to you?
There is no interference ← ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ → There is total interference

13 Do you need the help of your family and friends to complete everyday tasks (including work outside the home and housework) because of your pain
I never need help ← ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ → I need help all the time

14 Do you now feel more depressed, tense, or anxious than before your pain began?
There is n depression / tension ← ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ → There is severe depression / tension

15 Are there emotional problems caused by your pain that interfere with your family, social, and / or work activities
There is no problems ← ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ → There are severe problems

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PAST MEDICAL HISTORY Mark all that apply

☐ *Head Problems*	☐ Head Injuries	☐ Concussions	☐ Strokes	☐ TIA's	☐ Head Tumors
☐ Alzheimer's	☐ Brain Tumor	☐ Cerebral Palsy	☐ Poor Memory	☐ Poor Speech	☐ Sided Weakness
☐ *Headaches*	☐ Cluster	☐ Migraines	☐ Tension	☐ Whiplash	☐ Seizures
☐ *Eye Problems*	☐ Blurred Vision	☐ Cataracts	☐ Double Vision	☐ Glaucoma	☐ Retina Problems
☐ *Ear Problems*	☐ Dizziness	☐ Hearing Loss	☐ Poor Balance	☐ Ear Ringing	☐ Vertigo
☐ *Nose Problems*	☐ Bloody Nose	☐ Deviated Septum	☐ Nasal Polyps	☐ Sinusitis	☐ Sleep Apnea
☐ *Throat Problems*	☐ Poor Speech	☐ Poor Swallowing	☐ Poor Teeth	☐ Fillings / Crowns	☐ Partial / Dentures
☐ *Heart Problems*	☐ Heart Attacks	☐ Heart Congestion	☐ Valve Disease	☐ Hyper-tension	☐ Hypo-tension
☐ *Lung Problems*	☐ Asthma	☐ Bronchitis	☐ COPD	☐ Emphysema	☐ Smoker
☐ *GI Problems*	☐ Ulcers	☐ Hiatal Hernia	☐ Gas / Bloating	☐ Constipation	☐ Diarrhea
☐ Gallbladder	☐ Liver Problems	☐ Cirrhosis	☐ Hepatitis Acute	☐ Hepatitis Chronic	☐ High Cholesterol
☐ High Lipids	☐ Irritable Bowel	☐ Leaky Gut	☐ GI Polyps	☐ Diverticulitis	☐ Bloody Stools
☐ Hemorrhoids	☐ Pancreatitis	☐ Diabetes Adult	☐ Diabetes juvenile	☐ IDDM	☐ NIDDM
☐ *Renal Disease*	☐ Bladder Disease	☐ Kidney Disease	☐ Kidney Stones	☐ Bladder Stones	☐ UTI's
☐ *Female Problems*	☐ Breast	☐ Inflammation	☐ Ovaries	☐ Uterine	☐ Menopause
☐ *Male Problems*	☐ Erection	☐ Impotency	☐ Prostratitis	☐ Testicular	☐ Andropause
☐ *Nerve Problems*	☐ Polyneuropathy	☐ Radiculopathy	☐ Myopathy	☐ Nerve Injuries	☐ MS
☐ *Hormone*	☐ Growth Hormone	☐ Estrogen	☐ Progesterone	☐ Testosterone	☐ Thyroid
☐ *Arthritis*	☐ Osteoarthritis	☐ Osteoporosis	☐ Rheumatoid	☐ Burger's	☐ Raynaud's
☐ Broken Bones	☐ Chest Wall Pain	☐ Fibromyalgia	☐ Ligament-s	☐ Sprain / Strains	☐ Tissue Tears
☐ *Infections*	☐ Bacterial	☐ Viral	☐ Fungal	☐ Parasites	☐ STD's
☐ TB Active	☐ TB Chronic	☐ HIV	☐ AIDS	☐ AIDS Related	☐ Tumors

☐ *Bleeding Disorders* ☐ Hemorrhages ☐ Clotting Disorders ☐ DVT-s ☐ Blood Clots ☐ Pulmonary Emboli

☐ *Psychological Disorder*	☐ Attention Disorders	☐ Anxiety / Panic Disorder	☐ Claustrophobia
☐ Depression	☐ Manic Depression	☐ Mood Disorder	☐ Obsessions
☐ Personality Disorder	☐ Post Traumatic Stress	☐ Schizophrenia	☐ Suicidal Thoughts
☐ Suicidal Attempts	☐ Thought Disorders	☐ Work Swing Shifts	☐ History of Violence
☐ Alcohol Abuse	☐ Drug Abuse	☐ Physical Abuse	☐ Sexual Abuse

☐ Cancer-s _____ ☐ Chemotherapy ☐ Radiation Tx

☐ Cancer-s _____ ☐ Chemotherapy ☐ Radiation Tx

☐ OTHER _____

☐ OTHER _____

☐ OTHER _____

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PAST INJURY HISTORY ***Mark all that apply and fill in the blanks as indicated***

	None	Number		None	Number		None	Number
Open Head Injuries	☐	_____	Closed Head Injuries	☐	_____	Concussions	☐	_____
Neck Injuries	☐	_____	Upper Back Injuries	☐	_____	Low Back Injuries	☐	_____
Auto Accidents	☐	_____	Work Accidents	☐	_____	Personal Accidents	☐	_____

What Bad Sprain / Strains _____

What Fractures _____

What Trauma Surgery-ies _____

What Trauma Surgery-ies _____

PAST SURGERY HISTORY ***Mark all that apply and Fill in the blanks as indicated***

Head	_____	Breast-s	_____
Eyes	_____	Uterus	_____
Ears	_____	Ovaries	_____
Nose	_____	Vagina	_____
Mouth	_____	Prostrate	_____
Teeth	_____	Testicles	_____
Throat	_____	Penis	_____
Neck	_____	Kidney-ies	_____
Chest	_____	Bladder	_____
Heart	_____	Blood Vessels	_____
Lungs	_____	Arteries	_____
Esophagus	_____	Veins	_____
Abdomen	_____	Skin	_____
Stomach	_____	C-Spine	_____
Small Intestine	_____	T-Spine	_____
Gallbladder	_____	LS-Spine	_____
Liver	_____	Bones / Joint-s	_____
Pancreas	_____	Bones / Joint-s	_____
Spleen	_____	_____	_____
Appendix	_____	_____	_____
Large Intestine	_____	_____	_____
Colon	_____	_____	_____
Rectum	_____	_____	_____

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Family Medical History Any Problems with Any of the following? Anything Else? Mark All That Applies

☐ Heart Disease ☐ High BP ☐ Low BP ☐ Stroke ☐ Cancer ☐ Diabetes ☐ Obesity
☐ Bruising ☐ Bleeding ☐ Clotting ☐ Thyroid ☐ Seizures ☐ Osteoporosis ☐ Glaucoma
☐ Smoking ☐ Alcohol Abuse ☐ Drug Abuse ☐ Physical Abuse ☐ Sexual Abuse ☐ Suicides ☐ Violence
☐ *OTHER* _____

Personal Social Functional History Mark All That Applies

You are ☐ Single ☐ Never Married ☐ Have a significant other ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
You live with ☐ Live alone ☐ Room Mate ☐ Friends ☐ Significant other ☐ Spouse ☐ Guardian ☐ In-Laws
You live with ☐ Family ☐ Parent-s ☐ Step Parent-s ☐ Grandparent-s ☐ Kid-s ☐ Sibling-s ☐ Step Sibling-s ☐ Grandkids
How many places do you live at ☐ One ☐ Two ☐ Three ☐ More _____ ☐ School ☐ Main home ☐ Seasonal / Vacation home
You live in a ☐ Homeless ☐ House ☐ Condo ☐ Dorm ☐ Apartment ☐ Mobile Home ☐ Skilled Living ☐ Nursing Home

How many PAIN Doctor-s have you seen in the Past ☐ _____ ***How many PAIN Doctor-s are you still seeing Now*** ☐ _____
Do or did they all work in your Local town or City ☐ Yes ☐ No ***How many different cities or towns are they located*** ☐ _____
Did or do you have to go to Another State-s for care ☐ Yes ☐ No ***What State-s*** ☐ _____
Do you still have to go to Another State-s for care ☐ Yes ☐ No ***What State-s*** ☐ _____
Have you ever had your pain prescriptions Lost ☐ Yes ☐ No ***How many times*** ☐ _____ ***I Got it back*** ☐ Yes ☐ No
Have you ever had your pain prescriptions Stolen ☐ Yes ☐ No ***How many times*** ☐ _____ ***I Got it back*** ☐ Yes ☐ No
Do you get your Medicines from the Doctors Office ☐ Yes ☐ No ***How Many Different Pharmacies do you use*** ☐ _____
Are you as good as you think you can get ☐ Yes ☐ No ***What do you want*** _____
How Often do you see your pain medicine doctor ☐ When ever I need to go ☐ Every _____ Week-s ☐ Every _____ Month -s
How Many Miles do you travel to see the pain doctor ☐ Less than 25 ☐ 25 to 50 ☐ 50-75 ☐ 75 –100 ☐ About _____ Mile -s

Any Personal History of the following ? Mark ALL that applies and fill in the blanks as needed.

☐ Tobacco Use	☐ Alcohol Abuse	☐ Drug Abuse	☐ Physical Abuse	☐ Sexual Abuse	☐ Violence	☐ Suicide Attempts
☐ Acid / LSD	☐ Club Drugs	☐ Cocaine	☐ Heroin	☐ Inhalants	☐ Marijuana	☐ Ecstasy/MDMA
☐ Meth	☐ PCP	☐ Prescriptions	☐ Steroids	☐ Caffeine	☐ Soft Drinks	☐ Diet Soft Drinks
☐ Cigarettes	☐ Cigars	☐ Snuff	☐ Chew	☐ Beer	☐ Wine	☐ Liquor
_____ Day	_____ Day	_____ Day	_____ Day	_____ Day	_____ Day	_____ Day
_____ Month	_____ Month	_____ Month	_____ Month	_____ Month	_____ Month	_____ Month

I used ☐ Tobacco products for _____ Years ***I used*** ☐ Alcohol for _____ Years ***I used*** ☐ Drugs for _____ Years
I stopped Tobacco products in _____ ***I stopped*** Alcohol in _____ ***I stopped*** Drugs in _____

Personal Adaptive Equipment that you use Mark ALL that applies and fill in the blanks as needed.

☐ Glasses ☐ Bi-focals ☐ Contacts ☐ Dentures ☐ Partials ☐ Hearing Aid ____ RT ____ Lft ☐ Cane ____ RT ____ Lft
☐ TENS unit ☐ E Stim unit ☐ FES Unit for Foot Drop ____ Right ____ Left ☐ FES Unit for Wrist Drop ____ Right ____ Left
☐ Crutches ☐ Walker ☐ Wheeled Walker ☐ Wheelchair ☐ Scooter ☐ Electric Wheelchair ☐ Adaption's done for vehicle

Traction ☐ Inversion Device ☐ Low Back Gravity ☐ Low Back Pneumatic ☐ Neck over door unit ☐ Neck Pneumatic
Compression Supports or Stockings _____
What Limb, Spine and Neck Braces _____
OTHER _____

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WHAT PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS ARE YOU TAKING?
PLEASE INCLUDE TOPICAL CREAMS, PACTHES, OINTMENTS, HERBS, VITAMINS & SUPPLIMENTS

Medication ______________________
It is used for? ______________________
Side Effects? ______________________

DOSE	# pills/patch	HOW OFTEN	DAY TOTAL
________	________	______ per hrs	________

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ______________________
It is used for? ______________________
Side Effects? ______________________

DOSE	# pills/patch	HOW OFTEN	DAY TOTAL
________	________	______ per hrs	________

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ______________________
It is used for? ______________________
Side Effects? ______________________

DOSE	# pills/patch	HOW OFTEN	DAY TOTAL
________	________	______ per hrs	________

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ______________________
It is used for? ______________________
Side Effects? ______________________

DOSE	# pills/patch	HOW OFTEN	DAY TOTAL
________	________	______ per hrs	________

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ______________________
It is used for? ______________________
Side Effects? ______________________

DOSE	# pills/patch	HOW OFTEN	DAY TOTAL
________	________	______ per hrs	________

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ______________________
It is used for? ______________________
Side Effects? ______________________

DOSE	# pills/patch	HOW OFTEN	DAY TOTAL
________	________	______ per hrs	________

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ______________________
It is used for? ______________________
Side Effects? ______________________

DOSE	# pills/patch	HOW OFTEN	DAY TOTAL
________	________	______ per hrs	________

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ______________________
It is used for? ______________________
Side Effects? ______________________

DOSE	# pills/patch	HOW OFTEN	DAY TOTAL
________	________	______ per hrs	________

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ______________________
It is used for? ______________________
Side Effects? ______________________

DOSE	# pills/patch	HOW OFTEN	DAY TOTAL
________	________	______ per hrs	________

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ______________________
It is used for? ______________________
Side Effects? ______________________

DOSE	# pills/patch	HOW OFTEN	DAY TOTAL
________	________	______ per hrs	________

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

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WHAT PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS ARE YOU TAKING?
PLEASE INCLUDE TOPICAL CREAMS, PACTHES, OINTMENTS, HERBS, VITAMINS & SUPPLIMENTS

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE	# pills/patch	HOW OFTEN	**DAY TOTAL**
______	______	______ per hrs	______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE	# pills/patch	HOW OFTEN	**DAY TOTAL**
______	______	______ per hrs	______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE	# pills/patch	HOW OFTEN	**DAY TOTAL**
______	______	______ per hrs	______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE	# pills/patch	HOW OFTEN	**DAY TOTAL**
______	______	______ per hrs	______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE	# pills/patch	HOW OFTEN	**DAY TOTAL**
______	______	______ per hrs	______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE	# pills/patch	HOW OFTEN	**DAY TOTAL**
______	______	______ per hrs	______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE	# pills/patch	HOW OFTEN	**DAY TOTAL**
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Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

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It is used for? ____________
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______	______	______ per hrs	______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE	# pills/patch	HOW OFTEN	**DAY TOTAL**
______	______	______ per hrs	______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE	# pills/patch	HOW OFTEN	**DAY TOTAL**
______	______	______ per hrs	______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

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Name ____________ **Last** ____________ **SSN #** ____________ **Date** ____________

WHAT PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS ARE YOU TAKING?
PLEASE INCLUDE TOPICAL CREAMS, PACTHES, OINTMENTS, HERBS, VITAMINS & SUPPLIMENTS

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE # pills/patch HOW OFTEN **DAY TOTAL**

______ ______ ______ per hrs ______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE # pills/patch HOW OFTEN **DAY TOTAL**

______ ______ ______ per hrs ______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE # pills/patch HOW OFTEN **DAY TOTAL**

______ ______ ______ per hrs ______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE # pills/patch HOW OFTEN **DAY TOTAL**

______ ______ ______ per hrs ______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE # pills/patch HOW OFTEN **DAY TOTAL**

______ ______ ______ per hrs ______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE # pills/patch HOW OFTEN **DAY TOTAL**

______ ______ ______ per hrs ______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE # pills/patch HOW OFTEN **DAY TOTAL**

______ ______ ______ per hrs ______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE # pills/patch HOW OFTEN **DAY TOTAL**

______ ______ ______ per hrs ______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE # pills/patch HOW OFTEN **DAY TOTAL**

______ ______ ______ per hrs ______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE # pills/patch HOW OFTEN **DAY TOTAL**

______ ______ ______ per hrs ______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

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Name _____ **Last** _____ **SSN #** _____ **Date** _____

EDUCATION? How far have you gotten so far? Please Mark All that best describes you.

☐ Grade School ☐ High School ☐ Associate's ☐ Master's ☐ Attorney ☐ DDS
☐ GED ☐ Trade School ☐ Bachelor's ☐ PHD ☐ Chiropractor ☐ Medical Doctor

Other _____

SCHOOL YEARS SPORTS or HOBBIES ? What ALL did you do? Please Mark All that best describes you.

Grade School? ☐ None ☐ _____
High School? ☐ None ☐ _____
Junior College? ☐ None ☐ _____
College? ☐ None ☐ _____
Military? ☐ None ☐ _____

Where you in the Military? ☐ YES ☐ NO ***How long?*** _____ ***What Rank?*** _____

What did you do? _____

WHAT IS YOUR CURRENT WORK STATUS?

Working now ? ☐ YES ☐ NO ☐ Self Employed ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Home-maker

Job ? _____ **Employed by** _____

Job Classification? ☐ Sedentary ☐ Light Duty ☐ Mild Duty ☐ Moderate Duty ☐ Heavy Duty ☐ Extreme Duty

What is the weight in pounds that you have to be able to handle as part of your job:

Routinely lift? ☐ 10-20 ☐ 20-30 ☐ 30-40 ☐ 40-50 ☐ 50-60 ☐ 60-100 ☐ 100-200 ☐ More
Occasionally lift? ☐ 10-20 ☐ 20-30 ☐ 30-40 ☐ 40-50 ☐ 50-60 ☐ 60-100 ☐ 100-200 ☐ More
Rarely Maximum lift? ☐ 10-20 ☐ 20-30 ☐ 30-40 ☐ 40-50 ☐ 50-60 ☐ 60-100 ☐ 100-200 ☐ More

Explain if needed _____

Started there? **DATE** ☐☐ Month ☐☐ Day ☐☐☐☐ Yr ***Been there?*** _____

Do you like your job ? ☐ YES ☐ NO **Why ?** _____

Any Work Restrictions ? ☐ YES ☐ NO ☐ Temporary ☐ Permanent _____

Are you Disabled? ☐ YES ☐ NO ☐ Partial ☐ Total _____

Any Old Work Injuries ? ☐ YES ☐ NO **How Many?** ☐☐☐ ***Your Recovery was?*** ☐ Partial ☐ Total

Explain if needed _____

Any Old Personal Injuries? ☐ YES ☐ NO **How Many?** ☐☐☐ ***Your Recovery was?*** ☐ Partial ☐ Total

Explain if needed _____

CURRENT SPORTS or HOBBIES? What ALL do you do? Please Mark All that best describes you.

☐ None ☐ _____
☐ None ☐ _____

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FUNCTIONAL QUESTIONS

Claim Number | | | | | | | | | | | | | | |

Using the classification below where do you belong? Mark the boxes as indicated.

0 **NO Problems** With Activities	**1** Mild Problems with Vigorous / Extreme Activities	**2** Moderate Interference Regular Activities **No Helper Needed**	**3** Severe Interference Minimal Activities **Some Help Needed**	**4** Extreme Interference **With ALL Activities** **Lots of Help Needed**

How does Your Condition Interfere with Daily Activities ?	**0** NO Problems Can do Activities	**1** Mild Problems with Vigorous Activities	**2** Moderate Interference No Helper Needed	**3** Severe Interference Some Help Needed	**4** Extreme Interference Lots of Help Needed
Personal Hygiene	☐	☐	☐	☐	☐
Urinating	☐	☐	☐	☐	☐
Defecating	☐	☐	☐	☐	☐
Brushing Teeth	☐	☐	☐	☐	☐
Combing Hair	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐
Communication	☐	☐	☐	☐	☐
Writing	☐	☐	☐	☐	☐
Typing	☐	☐	☐	☐	☐
Seeing	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Speaking	☐	☐	☐	☐	☐
Physical Activity	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Reclining	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐

How does Your Condition Interfere with Daily Activities ?	**0** NO Problems Can do Activities	**1** Mild Problems with Vigorous Activities	**2** Moderate Interference No Helper Needed	**3** Severe Interference Some Help Needed	**4** Extreme Interference Lots of Help Needed
Physical Activity	☐	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐	☐
Sensory Function	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Seeing	☐	☐	☐	☐	☐
Tactile Feeling	☐	☐	☐	☐	☐
Tasting	☐	☐	☐	☐	☐
Smelling	☐	☐	☐	☐	☐
Hand Items	☐	☐	☐	☐	☐
Grasping	☐	☐	☐	☐	☐
Lifting	☐	☐	☐	☐	☐
Touch Discrimination	☐	☐	☐	☐	☐
Sexual Function	☐	☐	☐	☐	☐
Orgasm	☐	☐	☐	☐	☐
Ejaculation	☐	☐	☐	☐	☐
Lubrication	☐	☐	☐	☐	☐
Erection	☐	☐	☐	☐	☐
Sleep, Restful Pattern	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

Who is your Helper? _____ ***Are they paid help?*** ☐ No ☐ Yes

They help out when **Day** ☐ No ☐ Yes **Afternoon** ☐ No ☐ Yes **Evening** ☐ No ☐ Yes **Night** ☐ No ☐ Yes

Weekdays ☐ No ☐ Yes **Weekends** ☐ No ☐ Yes **OR** _____

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☐ ***Job Requirements*** ***Please Mark All that best describes you.*** ☐ ***Job Restrictions***

What do you do _____ ***Employer*** _____

Been there ☐☐ Months ☐☐ Years **Working** ☐ Yes ☐ No **Off** ☐☐ Days ☐☐ Months ☐☐ Years

How many hours per day do you work there? ☐☐ ***How many days per week?*** ☐ ***How many weeks a year?*** ☐☐

Job Requirements ☐ Sedentary ☐ Light Duty ☐ Mild Duty ☐ Moderate Duty ☐ Heavy Duty ☐ Hazardous Duty

You are ☐ Right Handed ☐ Left Handed ☐ Both ***Your job requires*** ☐ Right Handed ☐ Left Handed ☐ Both

Job ☐ One Handed ☐ Two Handed ☐ Rapid Alternating Activities ☐ Rough Hand Activities ☐ Fine Hand Activities

Pounds Lifting Required Rarely ☐☐☐ Occasionally ☐☐☐ Frequently ☐☐☐ Continuous ☐☐☐

Tasks that are needed	***In a 8 hour shift how long are you required to do the following?***					***Can You do it without problems?***	
Laying Down	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Sitting	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Standing	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Walking	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Running	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Twisting	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Bending	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Pushing	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Pulling	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Grasping	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Lifting	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Climbing	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Rapid Work	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Rapid One Handed	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Rapid Both Hands	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Arms below Shoulders	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Arms at Shoulders	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Arms above Shoulders	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Alternating One Foot	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
Alternating Both Feet	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
_____	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it
_____	☐ N /A	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Continuous	☐ Can do it	☐ Can not do it

Restrictions until ☐☐ D ☐☐ M ☐☐☐☐ Yr _____ ***MJ Kohrman MD*** _____