

## Information and Instructions About Your Examination

I understand that I am here for an Independent Medical or Impairment Examination (IME); this means the doctor performing the evaluation is neither treating me nor an employee of whomever requested the IME (insurance company, third party administrator, attorney, governmental agency, employer, or physician). The purpose of the IME is to provide a thorough, objective evaluation of the specific condition(s) related to the injury or illness in question, as well as 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 is not a comprehensive medical examination. It will not provide advice or treatment or substitute for evaluation or treatment by my regular treating doctor. A patient-physician 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 prepared summarizing today's evaluation and sent to the requesting party. If I would like a copy of the report, I will contact them.

I understand that generally my evaluation will begin with the doctor obtaining a history of how my problem began, and what evaluation or treatment has been rendered since; utilizing information I provide verbally, and document on the history forms; as well as that contained within whatever records may be available for review. The doctor will then ask about my current symptoms and generally record a relatively brief past medical history, and other information such as my work status, etc. All information I provide may be included in the report.

After the interview, a physical examination of the relevant body part(s) will be conducted. I understand that I need not perform any maneuver I feel might cause injury or a worsening of my symptoms, and will immediately inform the examiner if anything he/she is doing is causing excessive discomfort so it can be stopped right away. Some pain, stiffness, or other symptoms are produced in most physical examinations of this sort, for instance, when touching a tender spot or checking how far a stiff joint can move, and such findings are helpful in understanding my condition. The IME, however, is not intended to cause 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 can't do, or if a certain test is causing too much discomfort, etc.

I also understand that I am permitted to have a chaperone present during the physical examination, at my request. I consent to the taking of digital photographs to document findings during the physical examination.

I have read and understand the aforementioned information and instructions. I authorize this physician or any co-examiner to obtain any information that may be of relevance to the condition(s) in question, and to release that information and results of this IME, (verbally or in writing) to the entity that has requested the IME.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

## Medical Evaluation Questionnaire

1. What is your full name? \_\_\_\_\_
2. What is your date of birth? \_\_\_\_\_
3. Are you?  Right handed  Left handed  Either
4. What is the date of your injury? \_\_\_\_\_
5. Have you ever had any previous problems or injuries, including any other work, recreational, or motor vehicle injuries?  
 Yes  No  Not sure

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Have you ever had any difficulties prior to the date of your injury which were similar to those you are now experiencing?  
 Yes  No  Not sure

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Please describe how your injury occurred: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. What problems did you have at that time? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. What did you do following the injury? \_\_\_\_\_  
\_\_\_\_\_

10. Have you had any additional injuries since the date of injury in question #4? \_\_\_\_\_  
\_\_\_\_\_

11. What is your greatest concern at this time? \_\_\_\_\_  
\_\_\_\_\_

**If you are not having difficulty with pain, proceed to question 18.**

12. Where is your pain located? \_\_\_\_\_  
\_\_\_\_\_

13. How would you describe your pain (ache, burn, sharp, etc.)? \_\_\_\_\_

14. What makes your pain worse? \_\_\_\_\_  
\_\_\_\_\_

15. What makes your pain better? \_\_\_\_\_  
\_\_\_\_\_

16. How frequent is your pain?
- Constant (present  $\frac{3}{4}$  to all of the time)
  - Frequent (present  $\frac{1}{2}$  to  $\frac{3}{4}$  of the time)
  - Occasional (present  $\frac{1}{4}$  to  $\frac{1}{2}$  of the time)
  - Intermittent (present less than  $\frac{1}{4}$  of the time)

17. On a scale from 0 (no pain) to 10 (excruciating pain),
- |  |         |             |              |
|--|---------|-------------|--------------|
|  | No pain | ←-----→     | Excruciating |
| a. What number would you put on your pain at this time?    | 1       | 2 3 4 5 6 7 | 8 9 10       |
| b. During the past month, what has it averaged?            | 1       | 2 3 4 5 6 7 | 8 9 10       |
| c. During the past month, what is the highest it has been? | 1       | 2 3 4 5 6 7 | 8 9 10       |
| d. During the past month, what is the lowest it has been?  | 1       | 2 3 4 5 6 7 | 8 9 10       |

18. Are you having any other difficulties (numbness, weakness, etc.)?  Yes  No  Not Sure

If yes, please describe the difficulties in detail. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. Are there any tasks difficult for you to perform?  Yes  No  Not Sure

If yes, please describe the tasks which are most difficult for you: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- a. How much can you lift occasionally? \_\_\_\_\_ lbs.
- b. Can you lift a gallon of milk?  Yes  No  Not sure
- c. Can you lift a heavy bag of groceries?  Yes  No  Not sure
- d. Can you lift a pail of water?  Yes  No  Not sure
- e. How long can you sit at one time? \_\_\_\_\_ Stand? \_\_\_\_\_ Walk? \_\_\_\_\_

20. Who were you employed by when you were injured? \_\_\_\_\_

21. How long had you been working there? \_\_\_\_\_

22. What was your job title? \_\_\_\_\_

23. What did this job involve? \_\_\_\_\_

\_\_\_\_\_

24. What type of work have you performed previously? \_\_\_\_\_

25. Have you held any other jobs since your injury?  Yes  No  
If yes, please describe: \_\_\_\_\_

26. What is your level of education? \_\_\_\_\_

27. Are you working now?  Yes  No  
If yes, please describe your present job: \_\_\_\_\_  
If no, when did you last work? \_\_\_\_\_

28. Has your doctor, or anyone, prescribed any work restrictions?  Yes  No  Not Sure  
If yes, please describe these restrictions: \_\_\_\_\_  
\_\_\_\_\_

28. Where do you live? \_\_\_\_\_

29. Who lives with you? \_\_\_\_\_

30. Please describe your typical day: \_\_\_\_\_

31. Are you involved in any significant activities or recreational pursuits?  Yes  No  Not Sure  
If yes, please describe: \_\_\_\_\_

In the past?  Yes  No  Not Sure  
If yes, please describe: \_\_\_\_\_

32. Do you smoke?  No  Yes, in the past but I quit  Yes, \_\_\_\_\_ packs per day

32. How many alcoholic beverages do you have per week? \_\_\_\_\_

33. Have you had any medical (non-surgical) hospitalizations?  Yes  No  Not Sure  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

34. Have you had any operations?  Yes  No  Not Sure  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

35. Are you taking any prescribed medications?  Yes  No  Not Sure  
If yes, please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

36. Are you allergic to any medication?  Yes  No  Not Sure  
If yes, please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

37. Have you had any other medical problems?  Yes  No  Not Sure  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

38. Do any diseases run in your family?  Yes  No  Not Sure  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

39. Please provide any other comments which may assist us in understanding your situation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Thank you for your assistance. At the time of the visit we will review this information in further detail.*

# Pain Drawing

Name \_\_\_\_\_ Date \_\_\_\_\_

## WHERE IS YOUR PAIN NOW?

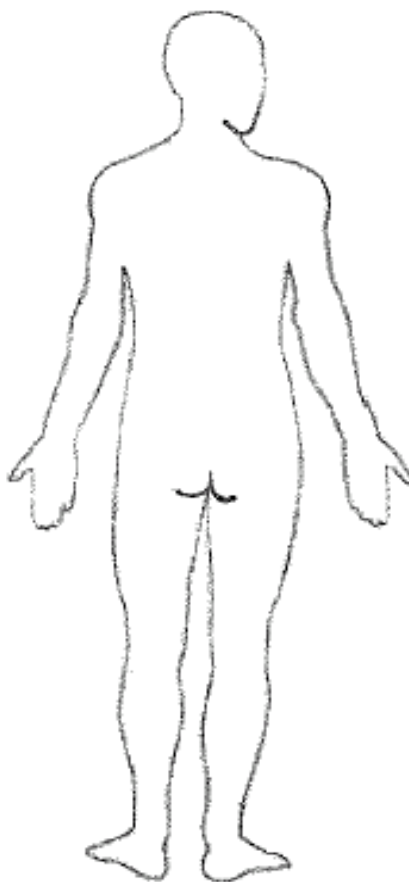
Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

SYMBOLS					
Aching	Numbness	Pins and Needles	Burning	Stabbing	Other
▲▲▲	= = =	○○○	X X X	///	●●●

FRONT VIEW



BACK VIEW



# Pain Disability Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?  
*Work normally* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Unable to work at all*
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?  
*Take care of myself completely* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Need help with all my personal care*
3. Does your pain interfere with your traveling?  
*Travel anywhere I like* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Only travel to see doctors*
4. Does your pain affect your ability to sit or stand?  
*No problems* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Cannot sit /stand at all*
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?  
*No problems* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Cannot do at all*
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?  
*No problems* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Cannot do at all*
7. Does your pain affect your ability to walk or run?  
*No problems* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Cannot walk/run at all*
8. Has your income declined since your pain began?  
*No decline* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Lost all income*
9. Do you have to take pain medication every day to control your pain?  
*No medication needed* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *On pain medication throughout the day*
10. Does your pain force you to see doctors much more often than before your pain began?  
*Never see doctors* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *See doctors weekly*
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?  
*No problem* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Never see them*
12. Does your pain interfere with recreational activities and hobbies that are important to you?  
*No interference* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Total interference*
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?  
*Never need help* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Need help all the time*
14. Do you now feel more depressed, tense, or anxious than before your pain began?  
*No depression/tension* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Severe depression / tension*
15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?  
*No problems* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Severe problems*

## QuickDASH

Please complete this if you are having problems with your arms.

Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer every question, based on your condition in the last week, by circling the appropriate number. If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	<i>No Difficulty</i>	<i>Mild Difficulty</i>	<i>Moderate Difficulty</i>	<i>Severe Difficulty</i>	<i>Unable</i>
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?

<i>Not at All</i>	<i>Slightly</i>	<i>Moderately</i>	<i>Quite A Bit</i>	<i>Extremely</i>
1	2	3	4	5

8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?

<i>Not Limited At all</i>	<i>Slightly Limited</i>	<i>Moderately Limited</i>	<i>Very Limited</i>	<i>Unable</i>
1	2	3	4	5

Please rate the severity of the following symptoms in the last week.

	<i>None</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>	<i>Extreme</i>
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?

<i>No Difficulty</i>	<i>Mild Difficulty</i>	<i>Moderate Difficulty</i>	<i>Severe Difficulty</i>	<i>So Much Difficulty That I Can't Sleep</i>
1	2	3	4	5

# AAOS Lower Limb Outcome Scale

Please complete this if you are having problems with your legs.

Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** These questions ask your views about your lower limb (leg).

	<i>Not at All</i>	<i>Mildly</i>	<i>Moderately</i>	<i>Very</i>	<i>Extremely</i>		
1. During the past week, how stiff was your lower limb?	1	2	3	4	5		
2. During the past week, how swollen was your lower limb?	1	2	3	4	5		
	<i>Not Painful</i>	<i>Mildly Painful</i>	<i>Moderately Painful</i>	<i>Very Painful</i>	<i>Extremely Painful</i>	<i>Could not do because of pain</i>	<i>Could not do because of Other</i>
3. Walking on flat surfaces?	1	2	3	4	5	6	7
4. Going up or down stairs?	1	2	3	4	5	6	7
5. Lying in bed at night?	1	2	3	4	5	6	7
	<i>Did not need support</i>	<i>Mostly walked without support</i>	<i>Mostly used 1cane / crutch</i>	<i>Mostly used 2 canes / crutches</i>	<i>Used a wheelchair</i>	<i>Mostly used other supports / someone</i>	<i>Unable to get around</i>
6. Which statements best describes your ability to get around most of the time during the <b>past week</b> ?	1	2	3	4	5	6	7
	<i>Not at All</i>	<i>Mildly</i>	<i>Moderately</i>	<i>Very</i>	<i>Extremely</i>	<i>Cannot do it at all</i>	
7. How difficult was it for you to put on or take off socks/stockings during the <b>past week</b> ?	1	2	3	4	5	6	

Please complete the following after your visit with the physician and provide this to the physician or the physician's staff prior to your departure.

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## Satisfaction Survey

Our goal is to provide the highest quality services. We welcome your feedback about today's visit. Please provide this to a member of our staff prior to your departure. Thank you.

- |   | Agree                    | Disagree                 |
|---|--------------------------|--------------------------|
| 1. I was treated with dignity and respect by the staff                | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. The physician appeared thoughtful and thorough                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I did NOT sustain any new or further difficulties during the exam. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Overall, I was pleased with the quality of today's visit.          | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

Name: \_\_\_\_\_ Date: \_\_\_\_\_