OCCUPATIONAL CONSULTING SERVICES - IME REGISTRATION

CONTACT/PERSONAL INFORMATION (Please type, or print clearly in blue ink only.)

Last Name _____ First Name _____ MI_____

Address _____ City, State, Zip _____

Phone (_____) _____-_____ SSN_____-_____-_____ Date of Birth_____/_____/_____ Age_____

Gender_____ Marital Status: □Married □Not Married Highest Education Level: High School 1 2 3 4 College 1 2 3 4

Dominant Hand: □Right □Left Tobacco? □NO □YES: _____ packs/day Alcohol? □NO □YES: _____ drinks/week

MEDICAL HISTORY/PREVIOUS INJURY

Have you ever had any medical conditions, past significant injuries or past surgeries involving **any of the same** body parts/areas you are being seen for today? □**NO** □**YES** **If YES, give details below. Check "WC" if it was work related:**

Date	Body Part	Condition/Injury (WC = Work Comp)	Treatment
_____	_____	□WC _____	□ PT □ Injections □ MRI/CT/EMG □ Surgery: _____
_____	_____	□WC _____	□ PT □ Injections □ MRI/CT/EMG □ Surgery: _____
_____	_____	□WC _____	□ PT □ Injections □ MRI/CT/EMG □ Surgery: _____
_____	_____	□WC _____	□ PT □ Injections □ MRI/CT/EMG □ Surgery: _____
_____	_____	□WC _____	□ PT □ Injections □ MRI/CT/EMG □ Surgery: _____

Below, please provide details for other medical conditions, past significant injuries or past surgeries **not related** to the body parts/areas you are being seen for today. Check "WC" if it was work related:

Date	Body Part	Condition/Injury (WC = Work Comp)	Treatment
_____	_____	□WC _____	□ PT □ Injections □ MRI/CT/EMG □ Surgery: _____
_____	_____	□WC _____	□ PT □ Injections □ MRI/CT/EMG □ Surgery: _____
_____	_____	□WC _____	□ PT □ Injections □ MRI/CT/EMG □ Surgery: _____
_____	_____	□WC _____	□ PT □ Injections □ MRI/CT/EMG □ Surgery: _____
_____	_____	□WC _____	□ PT □ Injections □ MRI/CT/EMG □ Surgery: _____

Are you currently taking any medications (prescription or over the counter) **for the injury/injuries** you are being seen for today? □NO □YES If YES, please list:

Please list any **other** medications you are currently taking:

EMPLOYMENT

As of today, are you employed/working? □NO □YES

Please list employment history for the last 10 years, beginning with current or most recent employer:

From	To	Employer	Position/Title
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HISTORY OF PRESENT INJURY (***If being seen for multiple DATES of injury, please use separate section for each date.)***

1. Date of Injury_____ Body Part(s) Injured _____

Describe injury in your words **(How did you get hurt?)**:

Employer at Time of Injury_____

Title/Position at Time of Injury _____ Length of Time in Position _____

Physical Job Duties: □grabbing/grasping □stooping/squatting □kneeling □pushing/pulling □reaching □twisting □lifting □bending □other:

Did you experience immediate pain and/or other symptoms? □NO □YES, please describe:

Did you lose consciousness? □NO □YES If YES, for how long? _____

Did you lose time from work as a result? □NO □YES If YES, how long?_____

Are you still in treatment for this injury? □NO □YES. If NO, were you released with permanent restrictions? □NO □YES
If permanent restrictions, please list:

2. Date of Injury_____ Body Part(s) Injured _____

Describe injury in your words **(How did you get hurt?)**:

Employer at Time of Injury_____

Title/Position at Time of Injury _____ Length of Time in Position _____

Physical Job Duties: □grabbing/grasping □stooping/squatting □kneeling □pushing/pulling □reaching □twisting □lifting □bending □other:

Did you experience immediate pain and/or other symptoms? □NO □YES, please describe:

Did you lose consciousness? (If YES, for how long?) □NO □YES: _____

Did you lose time from work as a result? □NO □YES If YES, how long?_____

Are you still in treatment for this injury? □NO □YES. If NO, were you released with permanent restrictions? □NO □YES
If permanent restrictions, please list:

3. Date of Injury_____ Body Part(s) Injured _____

Describe injury in your words **(How did you get hurt?)**:

Employer at Time of Injury_____

Title/Position at Time of Injury _____ Length of Time in Position _____

Physical Job Duties: □grabbing/grasping □stooping/squatting □kneeling □pushing/pulling □reaching □twisting □lifting □bending □other:

Did you experience immediate pain and/or other symptoms? □NO □YES, please describe:

Did you lose consciousness? (If YES, for how long?) □NO □YES: _____

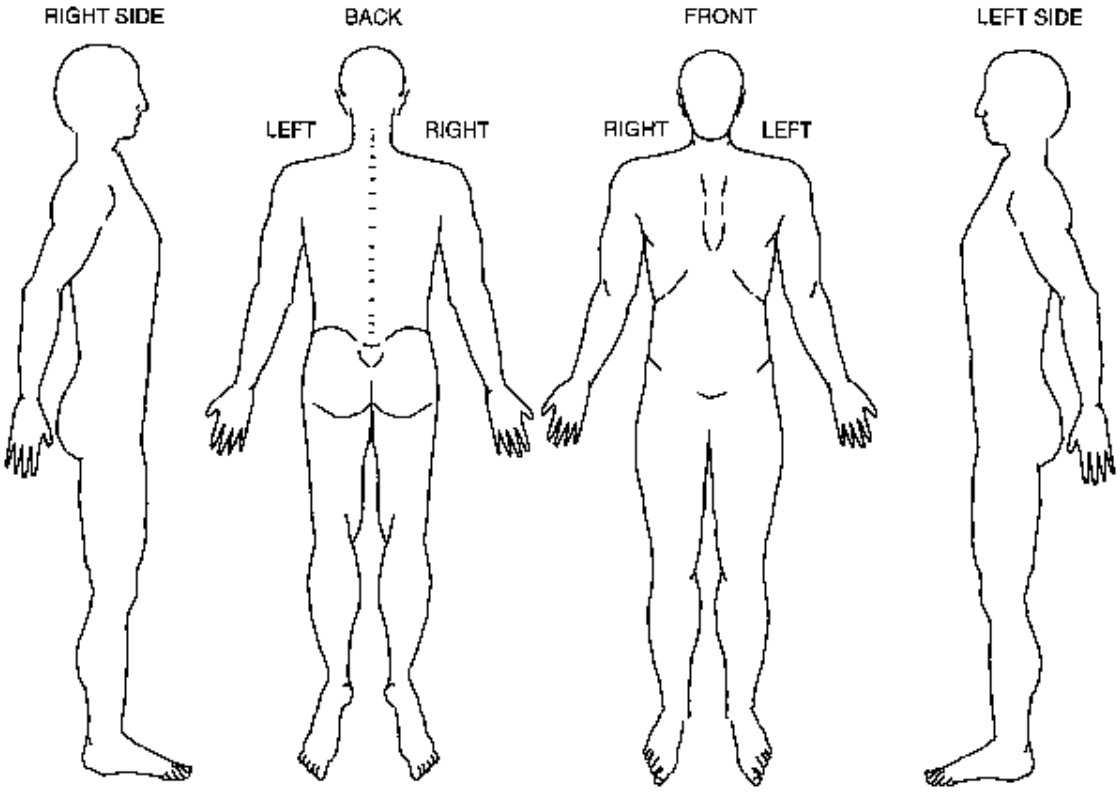
Did you lose time from work as a result? □NO □YES If YES, how long?_____

Are you still in treatment for this injury? □NO □YES. If NO, were you released with permanent restrictions? □NO □YES
If permanent restrictions, please list:

Last Name_____ First Name_____ MI_____

PAIN DIAGRAM – Please mark all areas of current pain/discomfort, as indicated:

AA = Aching ***BB = Burning*** ***SS = Stabbing*** ***NN = Numbness*** ***TT = Tingling***



ACTIVITIES OF DAILY LIVING – Relating to the body parts/areas you are being seen for today, please mark the number that best describes the current level of difficulty required to perform for each of the activities below.

0 = No difficulty / Not applicable ***3 = Some difficulty*** ***5 = Cannot Perform***

Self-care/Personal Hygiene	**0**	**3**	**5**
Urinating	☐	☐	☐
Defecating	☐	☐	☐
Brushing teeth	☐	☐	☐
Combing hair	☐	☐	☐
Dressing	☐	☐	☐
Eating	☐	☐	☐
Communication			
Writing	☐	☐	☐
Typing	☐	☐	☐
Seeing	☐	☐	☐
Hearing	☐	☐	☐
Speaking	☐	☐	☐
Eating	☐	☐	☐
Physical Activity			
Standing	☐	☐	☐
Sitting	☐	☐	☐
Reclining	☐	☐	☐
Walking	☐	☐	☐
Climbing stairs	☐	☐	☐

Sensory Function	**0**	**3**	**5**
Hearing	☐	☐	☐
Seeing	☐	☐	☐
*Tactile feeling	☐	☐	☐
Tasting	☐	☐	☐
Smelling	☐	☐	☐
Non-specialized Hand Activities			
Grasping	☐	☐	☐
Lifting	☐	☐	☐
*Tactile discrimination	☐	☐	☐
Sexual Function			
Orgasm	☐	☐	☐
Ejaculation	☐	☐	☐
Lubrication	☐	☐	☐
Erection	☐	☐	☐
Sleep/Restful Pattern	☐	☐	☐

**Can you tell the difference between sharp & dull objects touching your skin?*

Last Name_____ First Name_____ MI_____

PAIN/SYMPTOM DISABILITY QUESTIONNAIRE - These questions ask for your views about how your pain now affects the way you function in everyday activities. ***Please mark ONE number for each question below that best describes how you feel and provide WRITTEN examples for anything you mark 1 - 10.***

1. Does your pain interfere with your normal work inside and outside the home?

Work normally *Unable to work at all*

0 1 2 3 4 5 6 7 8 9 10

Example(s):

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely *Need help with all personal care*

0 1 2 3 4 5 6 7 8 9 10

Example(s):

3. Does your pain interfere with your traveling?

Travel anywhere I like *Only travel to see doctors*

0 1 2 3 4 5 6 7 8 9 10

Example(s):

4. Does your pain affect your ability to sit or stand?

No problems *Cannot sit/stand at all*

0 1 2 3 4 5 6 7 8 9 10

Example(s):

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No problems *Cannot do at all*

0 1 2 3 4 5 6 7 8 9 10

Example(s):

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

No problems *Cannot do at all*

0 1 2 3 4 5 6 7 8 9 10

Example(s):

7. Does your pain affect your ability to walk or run?

No problems *Cannot walk/run at all*

0 1 2 3 4 5 6 7 8 9 10

Example(s):

8. Has your income declined since your pain began?

No decline *Lost all income*

0 1 2 3 4 5 6 7 8 9 10

Example(s):

9. Do you have to take pain medication every day to control your pain?

No medication needed *On pain medication through day*

0 1 2 3 4 5 6 7 8 9 10

Example(s):

10. Does your pain force you to see doctors much more often than before your pain began?

Never see doctors *See doctors weekly*

0 1 2 3 4 5 6 7 8 9 10

Example(s):

11. Does your pain interfere with your ability to see people who are important to you (socialize with friends and family) as much as you would like?

No problem *Never see them*

0 1 2 3 4 5 6 7 8 9 10

Example(s):

12. Does your pain interfere with recreational activities and hobbies that are important to you?

No interference *Total interference*

0 1 2 3 4 5 6 7 8 9 10

Example(s):

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 *Need help all the time*

0 1 2 3 4 5 6 7 8 9 10

Example(s):

14. Do you now feel more depressed, tense, or anxious than before your pain began?

No depression/tension *Severe depression/tension*

0 1 2 3 4 5 6 7 8 9 10

Example(s):

15. Are there emotional problems caused by pain that interfere with family, social, and/or work?

No problems *Severe problems*

0 1 2 3 4 5 6 7 8 9 10

Example(s):

The above information is true, accurate and complete to the best of my knowledge and ability. I understand that my evaluation today is for the sole purpose of an independent medical evaluation, no patient-treating physician relationship will be established and no treatment will be provided at this office. I also understand that any/all information provided will not be confidential.

Printed Name: _____ Signature: _____

Any other person assisting with the completion of this form, please print your name and sign below:

Printed Name: _____ Signature: _____