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Independent Medical Evaluation
History Questionnaire

Instructions

Complete this history questionnaire, to the best of your ability, prior to your appointment. If you do not understand a question, simply leave it blank.

Please return your questionnaire to your attorney to be faxed to our office (515-964-9032) prior to your appointment, or bring your completed questionnaire to your appointment.

Note that your independent medical evaluation may last 2-3 hours depending on your situation. Please plan accordingly.

PATIENT INFORMATION

Your Full Name _____

Your Age _____

Are you Right Handed Left Handed Ambidextrous

History of the Injury

Outline in your own words what happened. Please be as specific as possible.

Current Clinical Status

What physicians or chiropractors, or other health care providers are you seeing for this condition at this time?

How often are you seeing your health care provider?

What medical treatments are you doing for **this problem** now? Please include any medications, physical therapy, stretching exercises or anything you do to help.
Meds –

PT –

Other –

Current Symptoms

Please outline your symptoms below. Try to include whether your pain is constant, the severity, where it is located, etc. Please be as specific as possible. We will go through this also during the evaluation.

Back pain patients only

What effect does coughing or sneezing have on your back pain?
Decrease/No Effect/Increase

What effect does bearing down to have a bowel movement have on your back pain?
Decrease/No Effect/Increase

Can you start and stop a stream of urine?	Yes	No
Can you control your bowel movements?	Yes	No
Do you get pain at the tip of your tailbone?	Yes	No
Does your whole leg ever become numb?	Yes	No
Does your whole leg ever become painful?	Yes	No
Does your whole leg ever give away?	Yes	No
Since your injury, have you had any period of time with very little back pain?	Yes	No

Please discuss any Yes answers in this space

On a scale from 0 (no pain) to 10 (excruciating pain):

What number would you give your pain at it's ***LOWEST***

_____

What number would you give your pain ***USUALLY***

_____

What number would you give your pain at it's ***HIGHEST***?

_____

Aggravating and relieving factors at home

If you have any problems with the following activities **AT HOME** please circle them. Please explain any circled answers in the space below the table:

Activity	Examples
Self-Care, Personal Hygiene	Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating
Communication	Writing, typing, seeing, trouble communicating because of a hearing or speaking problem,
Physical Activity	Standing, sitting, reclining, walking, climbing stairs, lifting, pushing pulling
Sensory function	Hearing, seeing, feeling with your fingers, tasting smelling
Nonspecified hand activities	Gripping, grasping, lifting, pushing, pulling, carrying, being able to tell dimes from quarters by touch alone
Travel	Riding, driving, flying
Sexual function	Orgasm, ejaculation, erection

Source: Table 1-2, The AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition

What do you do to reduce your symptoms, or make them better **AT HOME?**

Changes in Symptom Pattern

When you compare your symptoms now to a year ago are your symptoms
Worse/ About the Same/ Better

When you compare your symptoms now to six (6) months ago are your symptoms
Worse/ About the Same/ Better

When you compare your symptoms now to three (3) months ago are your symptoms
Worse/ About the Same/ Better

Past Medical History

Please list any **other medical** problems; any other illnesses or injuries at any time, not just this one? If you need more space, please continue on the back of this sheet.

Please list **any operations** you have had in the past. Include all surgeries, not just for the condition for which I am seeing you. If you need more space, please continue on the back of this sheet.

Have you ever had any **symptoms or injuries in the same location *before*** this injury? If so, please outline below. Include the year, and what happened.

If you have had any **previous impairment ratings** for the same body part, and if you can remember, what was the rating and when?

Have you ever had any **symptoms or injuries in the same location *since*** the injury?

Current Medications

Are you taking any prescription, nonprescription, vitamins or herbal medications? Please list, including doses and how often you take your medication.

Prescription medications	**Non prescription medications**	**Vitamins/Herbal Medications**

Allergies

Do you have any allergies to any medications? Do you have any Environmental Allergies (Hay fever)?

Social History

Do you smoke? No Yes, I smoked in the past, but I quit in _____ (year)
Yes, _____ packs per day for ___years

Do you use other forms of tobacco? Chewing Tobacco Cigars Pipe

How many alcoholic beverages do you drink per week? _____
What type of alcoholic beverage do you drink?

Do you currently use illegal substances? Have you ever had any work or legal problems due to drugs or alcohol?

Family Status

Are you: Married/Separated/Single/Divorced/Widowed

If you are married how long have you been married?

Where does your spouse/significant other work? What job do they perform?

Is your spouse/significant other in good health? Yes No If No, please explain:

Do you have any children? What are their ages and gender? Are your children in good health? If not please outline below as well.

Education

What was the last grade you completed in school? Where?

If you did not graduate from high school, why did you leave school early? Do you have a GED? If so, when and where did you earn your GED?

Military Service

Have you ever served in the military? (Yes or no)
If so in what branch and during what years?

Sleep Patterns

On average, how many hours of sleep do you get per night? ____ hours
Do you awaken with a sore throat or headache? (Yes or no)
Do you awaken rested in the morning? (Yes or no)

If you have problems getting a good night's sleep, please outline why you have problems sleeping below:

Sports and Hobbies

In what sports and/or hobbies did you participate before this injury?

Are you still able to participate in the sports and/or hobbies as before? (Yes or no) if not, why not?

Caffeine Intake

Caffeine intake per day - ____cups of coffee ___cups of tea _____soft drinks
Other:

At what time during the day do you stop your caffeine intake?

Social Security Disability Status

Are you on or applying for Social Security Disability Benefits? (Yes or No)
If you are on Social Security Disability Benefits, when were they granted?