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## Impairment Rating 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. We will review this with you at your appointment.

**Please return your questionnaire to your attorney to be e-mailed, faxed (515-964-9032), or mailed to our office prior to your appointment, and bring a copy of your completed questionnaire to your appointment.**

**Note** that your impairment rating appointment may last **1-2 hours** depending on your situation. Please plan accordingly.

# IMPAIRMENT RATING QUESTIONNAIRE

Your Full Name: \_\_\_\_\_

Your Age: \_\_\_\_\_

Are you:  Right Handed  Left Handed  Ambidextrous

**Please briefly outline:**

In your own words how the injury/illness occurred:

**Current Physician/Health Care Provider:**

I am not seeing any health care providers now.

Who is your doctor now? \_\_\_\_\_

How often are you seeing your physician, chiropractor, or other health care provider **for the problem for which I am seeing you?** \_\_\_\_\_

**Current Medical Treatment:**

What are you doing to treat the problem? Please list any medications, physical therapy or exercises, braces, etc. that you use, and how often you use them.

Medication: \_\_\_\_\_

Physical Therapy?  Yes  No

Exercise?  Yes  No

Other: \_\_\_\_\_

**Current Symptoms:**

Please outline your current symptoms; include location.

**Current Work Activities:**

Are you working now?  Yes  No

For the same employer?  Yes  No In the same job?  Yes  No

For a different employer?  Yes  No

If you work for a different employer, what company? \_\_\_\_\_

When did you start working here? \_\_\_\_\_

What job are you doing? \_\_\_\_\_

**Changes in Symptom Pattern:**

When you compare your symptoms now, to:

**One year ago:**  Better?  About the same?  Worse?

**Six months ago:**  Better?  About the same?  Worse?

**Three months ago:**  Better?  About the same?  Worse?

**Activities of Daily Living:**

Please check the following activities that cause you problems, **due to your injury**, at home.

Please check all that apply.

- |   |   |  |                                   |
|---|---|--|-----------------------------------|
| <input type="checkbox"/> Travel               | <input type="checkbox"/> Personal Hygiene | <input type="checkbox"/> Writing           | <input type="checkbox"/> Typing   |
| <input type="checkbox"/> Standing             | <input type="checkbox"/> Sitting          | <input type="checkbox"/> Reclining         | <input type="checkbox"/> Walking  |
| <input type="checkbox"/> Going up/down stairs | <input type="checkbox"/> Lifting          | <input type="checkbox"/> Pushing/pulling   | <input type="checkbox"/> Carrying |
| <input type="checkbox"/> Feeling with fingers | <input type="checkbox"/> Squatting        | <input type="checkbox"/> Grasping/gripping | <input type="checkbox"/> Intimacy |

**Past Medical History:**

Please list any operations/surgeries you have had in the past.


Please list any **OTHER MEDICAL (NON-SURGICAL)** problems you have or have had in the past:

**Prior and/or intervening injuries or illnesses in the same area:**

Have you ever had any injuries or illnesses in the same location before or since this injury or illness started?  Yes  No

If yes, please explain.

**Current Medications:**

Prescription Medications:	Non Prescription Medications:

**Allergies:**

Do you have any allergies to medications?  Yes  No

If yes, list medication(s):

**Disability Status:**

Are you on any disability now?  Yes  No

Are you applying for any disability benefits now?  Yes  No



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