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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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