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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.

☐ Travel	☐ Personal Hygiene	☐ Writing	☐ Typing
☐ Standing	☐ Sitting	☐ Reclining	☐ Walking
☐ Going up/down stairs	☐ Lifting	☐ Pushing/pulling	☐ Carrying
☐ Feeling with fingers	☐ Squatting	☐ Grasping/gripping	☐ 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):

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