PAIN QUESTIONNAIRE FOR PATIENTS WITH

INJURY

(Please complete this form and bring it with you on your visit)

# Last name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: Mr.\_\_\_ Mrs.\_\_\_ Dr.\_\_\_

# Appt Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Treating Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Please provide name and address of Doctor, of whom you want this report to be send to)

Age:\_\_\_\_\_ Dominant hand: R\_\_\_ L\_\_\_ Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Chief Complaints**: (What is bothering you? What symptoms brought you to see the doctor? For example: severe lower back pain with pain going down to the right leg):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **HISTORY OF INJURY**(at time of injury):

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury? \_\_\_\_\_\_\_\_ Mechanism of Injury (example: fall, Lifting, cumulative trauma)?\_\_\_\_\_\_

Describe What Happened during Injury in detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Which are the Injured Body Parts*? (check all appropriate box)**

head\_\_\_ Neck\_\_\_ R. shoulder\_\_\_ L. shoulder\_\_\_ R. arm\_\_\_ L. arm\_\_\_ Upper back\_\_\_ Mid back\_\_\_ lower back\_\_\_ R. Hip\_\_\_ L Hip\_\_\_ R. thigh\_\_\_ L. thigh\_\_\_ R. Knee\_\_\_

L. Knee\_\_\_ R. leg\_\_\_ L leg\_\_\_ R. ankle\_\_\_ L. Ankle\_\_\_ R. foot \_\_\_ L. foot\_\_\_ OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial Injury**: ***Your first symptoms***? Pain\_\_\_ Weakness\_\_\_ Numbness\_\_\_ Tingling\_\_\_\_ swelling\_\_\_ Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you report the injury immediately? Yes\_\_\_ No\_\_\_; If no, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of doctor/clinic where you were first seen\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized for this injury? Yes\_\_\_, No\_\_\_; hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What were your initial treatments: Medication\_\_\_\_ X-ray \_\_\_ Therapy \_\_\_\_ Other:\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment status after injury**:

Dates you were unable to work (as result of injury): From\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you returned to work (where injury happened)? Yes\_\_\_ No\_\_\_ ; if yes: date:\_\_\_\_\_\_\_\_\_

1. ***WORK & INJURY HISTORY (For the job you were working at the time of your injury)***

***Employment duration****: Date of hire:\_\_\_\_\_\_\_\_\_ last day on this job?\_\_\_\_\_\_\_\_\_\_\_*

***Job Description: (****Description of usual duties): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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***Current work status:***

Are you currently working? Yes\_\_\_ No\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_ Job title: \_\_\_\_\_\_\_\_\_\_\_

What is your current work restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Previous work experience***:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| EMPLOYER | JOB TITLE | START DATE | END DATE | INJURY(exp.: neck, back, knee) |
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***Past Injury( includes all injuries):***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date | Mechanism: (exp: car accident, fall, lifting, sports) | Body parts: (exp: neck, back, knee) | Compensation$ | Treatment: (chiro, therapy,medication,surgery) |
|  |  |  |  |  |
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ADDITIONAL EXPLANATION FOR INJURY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Studies to date*(check all appropriate box):***:* X-ray date:\_\_\_\_\_\_\_ CT date:\_\_\_\_\_\_\_

EMG date:\_\_\_\_\_\_\_\_\_ Myelogram date:\_\_\_\_\_\_\_ MRI date:\_\_\_\_\_\_\_\_\_\_\_\_\_ DISCOGRAM Date:\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Treatment so far* (check all appropriate box):**

Anti-inflammatory medications\_\_\_ Pain medication\_\_\_ Physical therapy\_\_\_ Brace\_\_\_ Chiropractor\_\_\_ Acupuncture\_\_\_ pool therapy \_\_\_ cervical traction\_\_\_

Trigger point Injection \_\_\_ Epidural injection \_\_\_ Facet injection\_\_\_ SI injection

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

***4*. PRESENT SYMPTOM*: (PLEASE DO ONE BODY PART AT A TIME)***

***1st body part ( start with the most symptomatic body part)****:*

*(location)* ***Where does it hurt now*? (check 1st body part)**

head\_\_\_ Neck\_\_\_ R. shoulder\_\_\_ L. shoulder\_\_\_ R. arm\_\_\_ L. arm\_\_\_ Upper back\_\_\_ Mid back\_\_\_ lower back\_\_\_ R. Hip\_\_\_ L Hip\_\_\_ R. thigh\_\_\_ L. thigh\_\_\_ R. Knee\_\_\_

L. Knee\_\_\_ R. leg\_\_\_ L leg\_\_\_ R. ankle\_\_\_ L. Ankle\_\_\_ R. foot \_\_\_ L. foot\_\_\_ OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Association)****Radiation of pain***(example: pain radiate down to top of foot or numbness going down to finger tips): Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Quality)* ***Please characterize the discomfort***:

# Numbness\_\_\_ Pins &needles\_\_\_ ache\_\_\_ burning \_\_\_Stabbing\_\_\_ throbbing\_\_\_

*(Severity*) ***Pain rating based on scale of 10*** (0= no pain, 10=severe pain that you would rather die)?

(0\_\_\_\_\_ 1\_\_\_\_\_ 2\_\_\_\_\_ 3\_\_\_\_\_ 4\_\_\_\_\_ 5\_\_\_\_\_ 6\_\_\_\_\_ 7\_\_\_\_\_ 8\_\_\_\_\_ 9\_\_\_\_ 10\_\_\_\_)

*(Timing)* **What time of the day is your discomfort worsen:**

Morning\_\_\_ later in the day\_\_\_ mid. Of the night\_\_\_ constant without relief\_\_\_ Random\_\_\_

***(Factors aggravate or relief the symptoms)*:** Better worse no different

# Standing \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Walking \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

# Sitting \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

# Bending forward \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Bending backwards \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Lying flat on back \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Lying on my side with knees bent \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

With cough, sneeze, straining during bowl movements \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Activities (vacuuming carpets, mowing lawn) \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Exercise (jogging, aerobics) \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Cold, damp weather \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Heating pack \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

***2nd body part****:*

*(location)* ***Where does it hurt now*? (Please check 2nd most symptomatic body part below)**

head\_\_\_ Neck\_\_\_ R. shoulder\_\_\_ L. shoulder\_\_\_ R. arm\_\_\_ L. arm\_\_\_ Upper back\_\_\_ Mid back\_\_\_ lower back\_\_\_ R. Hip\_\_\_ L Hip\_\_\_ R. thigh\_\_\_ L. thigh\_\_\_ R. Knee\_\_\_

L. Knee\_\_\_ R. leg\_\_\_ L leg\_\_\_ R. ankle\_\_\_ L. Ankle\_\_\_ R. foot \_\_\_ L. foot\_\_\_ OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Association)****Radiation of pain***(example: pain radiate down to top of foot or numbness going down to finger tips): Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Quality)* ***Please characterize the discomfort***:

# Numbness\_\_\_ Pins &needles\_\_\_ ache\_\_\_ burning \_\_\_Stabbing\_\_\_ throbbing\_\_\_

*(Severity*) ***Pain rating based on scale of 10*** (0= no pain, 10=severe pain that you would rather die)?

(0\_\_\_\_\_ 1\_\_\_\_\_ 2\_\_\_\_\_ 3\_\_\_\_\_ 4\_\_\_\_\_ 5\_\_\_\_\_ 6\_\_\_\_\_ 7\_\_\_\_\_ 8\_\_\_\_\_ 9\_\_\_\_ 10\_\_\_\_)

*(Timing)* **What time of the day is your discomfort worsen:**

Morning\_\_\_ later in the day\_\_\_ mid. Of the night\_\_\_ constant without relief\_\_\_ Random\_\_\_

***(Factors aggravate or relief the symptoms)*:** Better worse no different

# Standing \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Walking \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

# Sitting \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

# Bending forward \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Bending backwards \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Lying flat on back \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Lying on my side with knees bent \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

With cough, sneeze, straining during bowl movements \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Activities (vacuuming carpets, mowing lawn) \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Exercise (jogging, aerobics) \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Cold, damp weather \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Heating pack \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

***3rd body part****:*

*(location)* ***Where does it hurt now*? (Please check the 3rd body part below)**

head\_\_\_ Neck\_\_\_ R. shoulder\_\_\_ L. shoulder\_\_\_ R. arm\_\_\_ L. arm\_\_\_ Upper back\_\_\_ Mid back\_\_\_ lower back\_\_\_ R. Hip\_\_\_ L Hip\_\_\_ R. thigh\_\_\_ L. thigh\_\_\_ R. Knee\_\_\_

L. Knee\_\_\_ R. leg\_\_\_ L leg\_\_\_ R. ankle\_\_\_ L. Ankle\_\_\_ R. foot \_\_\_ L. foot\_\_\_ OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Association)****Radiation of pain***(example: pain radiate down to top of foot or numbness going down to finger tips): Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Quality)* ***Please characterize the discomfort***:

# Numbness\_\_\_ Pins &needles\_\_\_ ache\_\_\_ burning \_\_\_Stabbing\_\_\_ throbbing\_\_\_

*(Severity*) ***Pain rating based on scale of 10*** (0= no pain, 10=severe pain that you would rather die)?

(0\_\_\_\_\_ 1\_\_\_\_\_ 2\_\_\_\_\_ 3\_\_\_\_\_ 4\_\_\_\_\_ 5\_\_\_\_\_ 6\_\_\_\_\_ 7\_\_\_\_\_ 8\_\_\_\_\_ 9\_\_\_\_ 10\_\_\_\_)

*(Timing)* **What time of the day is your discomfort worsen:**

Morning\_\_\_ later in the day\_\_\_ mid. Of the night\_\_\_ constant without relief\_\_\_ Random\_\_\_

***(Factors aggravate or relief the symptoms)*:** Better worse no different

# Standing \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Walking \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

# Sitting \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

# Bending forward \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Bending backwards \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Lying flat on back \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Lying on my side with knees bent \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

With cough, sneeze, straining during bowl movements \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Activities (vacuuming carpets, mowing lawn) \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Exercise (jogging, aerobics) \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Cold, damp weather \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Heating pack \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

***Self-assessment of current condition*, (without interruption)-**

How long are you able to walk? \_\_\_\_\_\_\_ How long are you able to stand? \_\_\_\_\_\_\_\_\_

How long are you able to sit?\_\_\_\_\_\_\_\_\_\_\_\_

Can you continue current occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If you had prior neck or back surgeries please complete this box:*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of surg. | Surgeon | Reason for surgery | Type of procedures | Did symptoms improve post-op? |
|  |  |  |  |  |
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|  |  |  |  |  |

**Past Medical history (example: diabetes, high blood pressure, Panic disorder)**

**Past Surgical History (other than neck or back surgery**)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date  | Surgeon | City | Diagnosis | procedures |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Allergies to medication:**

|  |  |
| --- | --- |
| Name of medication | Reaction after taken medication |
|  |  |
|  |  |
|  |  |

**Medication:**

|  |  |  |
| --- | --- | --- |
| Name of medication | Dosage (mg) | # of times per day |
|  |  |  |
|  |  |  |
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|  |  |  |
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**Social History:**

Marital status?: \_\_\_single \_\_\_married \_\_\_Divorced

How much do you smoke? :\_\_\_ none, \_\_\_yes (# of pack per day\_\_\_\_\_, # of years\_\_\_\_\_\_\_\_\_)

How much do you drink? :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently employeed? \_\_\_yes, \_\_\_No.

How long have you not been working? (\_\_\_\_\_)

Is there attorney or litigation involved or in your case? \_\_\_yes, \_\_\_no.

**Family History**:

Father \_\_\_alive \_\_\_deceased Cause of death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother \_\_\_alive \_\_\_deceased Cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other disease in the family (exp: bleeding disease,diabetes): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Review of Systems: (Check all appropriate, leave line blank if does not apply to you)***

***1. Neurological***:

Do you have difficulty with walking, falling?\_\_\_ Do you experience clumsiness with your hands? Dropping objects?\_\_\_ Do you have difficulty control your bowel or bladder?\_\_\_\_\_\_

***2. Constitutional:***

Do you have recent unintentional weight loss?\_\_ Do you have recent fever, chill, night sweats?\_\_\_

***Review of Systems continue***: (***check all appropriate, leave line blank if does not apply to you*** )

1. ***Eyes:***

Glaucoma\_\_\_ eye infection\_\_\_ nearside\_\_\_ farside\_\_\_ blurring\_\_\_ cataract\_\_\_

1. ***Ear, Nose, throat, mouth***:

Discharge\_\_\_ ringing in ear\_\_\_ nose bleed\_\_\_ dizziness\_\_\_ infection\_\_\_

1. ***Cardiovascular:***

Chest pain\_\_\_ high blood pressure\_\_\_ heart murmur\_\_\_ irregular pulse\_\_\_

1. ***Respiratory:***

# Asthma\_\_\_ bronchitis\_\_\_ pneumonia\_\_\_ TB\_\_\_ chronic cough\_\_\_

1. ***Gastrointestinal:***

Nausea\_\_\_ vomiting\_\_\_ diarrhea\_\_\_ abdominal pain\_\_\_ liver problem\_\_\_

Coughing up blood\_\_\_ hemorrhoids\_\_\_

1. ***Genitourinary:***

Painful urination\_\_\_ kidney stone\_\_\_ blood in urine\_\_\_ urinary infection\_\_\_

1. ***Musculoskeletal:***

Prior fractures\_\_\_ weakness\_\_\_ joint swelling/pain\_\_\_ arthritis\_\_\_ gout\_\_\_

1. ***Skin***:

Breast lump\_\_\_ rashes\_\_\_ Scar\_\_\_ nipple discharge\_\_\_ skin disease\_\_\_

1. **Psychiatric:**

Depression\_\_\_ schizophrenia\_\_\_ bipolar\_\_\_ anxiety\_\_\_ headache\_\_\_

1. ***Endocrine:***

Diabetes\_\_\_ heat or cold intolerance\_\_\_ thyroid disease\_\_\_ goiter\_\_\_

1. ***Blood:***

Anemia\_\_\_ bleeding tendencies\_\_\_ easy bruising\_\_\_ blood transfusions\_\_\_low platelet\_\_\_

1. ***Allergy:***

Hives\_\_\_ itching\_\_\_

1. ***Genitoreproductives:***

Venereal disease\_\_\_ discharge\_\_\_ hernias\_\_\_menopause\_\_\_difficulty intercourse\_\_\_



**ACTIVITIES OF DAILY LIVING COMMONLY**

**MEASURED IN ACTIVITIES OF DAILY LIVING (ADL)\***

(Based on Pg. 4 Guides to the Evaluation of Permanent Impairment, 5th Edition)

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **APPLICANT HAS DIFFICULTY WITH:** (Mark with an “X” below and explain where indicated) |
|  | **CATEGORY OF ACTIVITY**  | ACTIVITY | **Without Difficulty** | **With Some Difficulty** | **With Much Difficulty** | **Mostly Unable to Do** |
| **1.** | Self-care, personal hygiene(Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating) | Take a shower |  |  |  |  |
| Take a bath |  |  |  |  |
| Wash & dry body |  |  |  |  |
| Wash & dry face |  |  |  |  |
| Turn on/off faucets |  |  |  |  |
| Brush teeth |  |  |  |  |
| Get on/off toilet |  |  |  |  |
| Comb/brush hair |  |  |  |  |
| Dress self |  |  |  |  |
| Put on/off shoes/socks |  |  |  |  |
| Open carton of milk |  |  |  |  |
| Open a jar |  |  |  |  |
| Lift glass/cup to mouth |  |  |  |  |
| Make a meal |  |  |  |  |
| Lift fork/spoon to mouth |  |  |  |  |
| Describe other: (bladder and bowel function difficulties: incontinence, retention, constipation?) |
| **2.** | **Physical activity**(Standing, sitting, reclining, walking, climbing stairs) | Stand |  |  |  |  |
| Sit |  |  |  |  |
| Recline |  |  |  |  |
| Rise from a chair |  |  |  |  |
| Get in/out of bed |  |  |  |  |
| Climb flight of 10 stairs |  |  |  |  |
| Work outdoors |  |  |  |  |
| Light housework |  |  |  |  |
| Shop/do errands |  |  |  |  |
| Carry groceries |  |  |  |  |
| Lift 5 lbs. |  |  |  |  |
| Lift 10 lbs.  |  |  |  |  |
| Lift 20 lbs. |  |  |  |  |
| Lift 30 lbs. |  |  |  |  |
| Walk |  |  |  |  |
| Care for children or parents |  |  |  |  |
| Engage in hobbies (music or crafts, etc.) Indicate hobby: |  |  |  |  |
| Describe other: (eating/chewing difficulty: TMJ?) |
|  |
| **APPLICANT HAS DIFFICULTY WITH:** (Mark with an “X” below and explain where indicated) |
|  | **CATEGORY OF ACTIVITY** | ACTIVITY | **Without Difficulty** | **With Some Difficulty** | **With Much Difficulty** | **Mostly Unable to Do** |
| **3.** | **Communication**(Writing, typing, seeing, hearing, speaking) | Write a note |  |  |  |  |
| Type a message on a computer/typewriter |  |  |  |  |
| See a television screen |  |  |  |  |
| Use a telephone |  |  |  |  |
| Speak clearly |  |  |  |  |
| Hear clearly |  |  |  |  |
| Describe other:  |
| **4.** | **Nonspecified hand activities**(Grasping, lifting, tactile, discrimina-tion) | Pick up small items |  |  |  |  |
| Turn a knob on a door |  |  |  |  |
| Write with a pen/pencil |  |  |  |  |
| Steer wheel of car |  |  |  |  |
| Describe other: |  |  |  |  |
| **5.** | **Sensory function**(Hearing, seeing, tactile feeling, tasting, smelling) | Feel what you touch |  |  |  |  |
| Taste what you eat |  |  |  |  |
| Smell what you eat |  |  |  |  |
| Describe other: |
| **6.** | **Travel**(Riding, driving, flying) | Get in/out of a car |  |  |  |  |
| Drive a car |  |  |  |  |
| Ride in a car |  |  |  |  |
| Fly in a plane |  |  |  |  |
| Ride a bicycle |  |  |  |  |
| Describe other: |
| **7.** | **Sexual function**(Orgasm, ejacula-tion, lubrication, erection) | Engage in sexual activity |  |  |  |  |
| Describe specific difficulty: (Orgasm, ejaculation, lubrication, erection?) |
| **8.** | **Sleep**(Restful sleep, nocturnal sleep pattern) | Get to sleep |  |  |  |  |
| Sleep through the night |  |  |  |  |
| Have restful sleep |  |  |  |  |
| Feel refreshed after sleep |  |  |  |  |
| Describe specific difficulty: (teeth grinding at night, excessive daytime fatigue, irritability, etc.) |