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Impairment Rating Patient History Questionnaire

Instructions

Complete this history questionnaire, to the best of your ability, prior to your appointment with Dr. Kuhnlein. If you do not understand a question, simply leave it blank, as you will be reviewing the information with Dr. Kuhnlein in the exam room.

Bring the questionnaire to your appointment and present it when you check in at the front desk.

Note that your impairment rating appointment 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

Please outline below what happened to you. Be as specific as possible.

Current Work Activities

What job are you currently doing? If it is the same job as the injury job please circle

SAME JOB

If you are working in a different job for the same employer, please describe what job you are doing now.

How long have you been doing this job?

Please describe your job duties now:

Are any JOB tasks difficult for you to perform?

If yes, please circle the task and describe below the tasks that are difficult for you to perform:

Lifting	Pushing	Pulling	Carrying	Walking
Sitting	Standing	Stooping	Crawling	Kneeling
Working outdoors	Using arms	Using legs	Using personal protective gear	Using tools/power tools
Working on ladders	Going up/down stairs	Pinching	Gripping	Grasping

Other: _____

Current Care

Current physician/health care provider

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.

Current Symptoms

Please outline your current symptoms; include location – where on your body you hurt or are numb, etc.

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

What number would you give your pain

TODAY? _____

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

What number would you give your pain

USUALLY? _____

What number would you give your pain at its

LOWEST? _____

What number would you give your pain at its

HIGHEST? _____

Aggravating Factors – What do you do that makes your symptoms worse?

Relieving Factors – What do you do that makes your symptoms better?

Symptom Changes Over Time –

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

Activities of Daily Living –

If you have any problems with the following activities **at home** please circle them.
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
Sleep	Frequent awakening, not awakening rested

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

Explain circled answers

Lost Time for this Injury/Illness – How much time did you miss from work as a result of this injury. Please be as specific as possible.

Past Medical History

Please list any other medical or surgical conditions below.

Medical Conditions –

Surgeries –

Prior and/or intervening injuries or illnesses in the same area – Have you had any injuries or illnesses in the same location before or since this injury or illness started?

Current Medications

What prescription medications do you take?

What non-prescription medications do you take?

What vitamins, minerals, herbal/natural medications do you take?

Allergies

Are you allergic to any medications? If so, please list them here.

Social History

Tobacco use – Do you smoke? If so, how many packs per day? How many years have you smoked? Do you use any other type of tobacco, such as chewing tobacco, pipes or cigars? If so, what do you use?

Alcohol Use – How much alcohol do you drink in a week's time?

Illegal Substance Use – Do you use illegal drugs now? Have you ever used illegal drugs?

Family – Are you married/single/divorced/widowed
If married or you have a significant other, are they in good health?

How many children do you have? What are their ages?

Education – What was the last grade you completed in school?

If you did not formally complete high school do you have a GED? If so, when did you earn your GED?

Military Service - Have you ever served in the military?
If so in what branch and during what years?

Sleep Patterns - On average, how many hours of sleep do you get per night? _____
If you have problems getting a good night's sleep, please outline why you have problems sleeping below:

Sports and Hobbies – Please list any sports or hobbies you participate in now.

Caffeine Intake – How much of the following do you drink in a day?

Caffeine intake per day - _____ cups of coffee _____ cups of tea _____ soft drinks (cans or bottles)

Social Security Disability Status

Are you receiving/applying for Social Security Disability Income Benefits? (Yes or No)
If yes, when did you begin to receive benefits?

Family History

Describe any illnesses that affect your immediate family (i.e., mother, father, siblings)

Medix

Medicine at Work

1241 Park Place NE, Suite A
Cedar Rapids, IA 52402

Print Directions

From the south, take I-380 to the Collins Road exit.

Get Mapquest directions

