Medix Occupational Health Services
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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

Please briefly outline:

In your own words how the injury/illness occurred:

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.

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?

Please describe your job duties now:

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 Standing	☐ Personal Hygiene	☐ Writing	☐ Typing
☐ Climbing Stairs	☐ Sitting	☐ Reclining	☐ Walking
☐ Feeling w/Fingers	☐ Lifting	☐ Pushing	☐ Pulling
☐	☐ Gripping	☐ Grasping	☐ Intimacy

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?

☐ Yes ☐ No If yes, 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 receiving/applying for Social Security Disability Income Benefits or any other Disability Benefits? ☐ Yes ☐ No

If yes, when did you begin to receive benefits? _____

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