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Missouri Life Care Plans
Board Certified Emergency Medicine
Certified Life Care Planner

PATIENT INFORMATION:

Name: ____
Address: ____
Phone: ____
Last 4 digits of SSN: ______________ **Birthdate:** _____________ **Age:** ______ **Sex:** ____

Date of Injury: ____
Employer at Time of Injury: ____
Occupation: ____
Attorney's Name: ____
Date of Exam: ____

Welcome

You will be seen for a medical evaluation which may be known as an independent medical evaluation, impairment evaluation, qualified medical evaluation, or agreed medical evaluation.

During this visit no treating physician/patient relationship will be established. The purpose of this visit is to answer specific questions concerning your case and to prepare a report. The information that you share with us will be included in the report. If you or anyone else needs a copy of this report, it is best to obtain it directly from your attorney.

We will review your history, medical records, and any available studies. We will also perform a physical examination. Please let us know immediately if you have any difficulties whatsoever during the assessment.

We also ask that you complete the attached materials which will provide us with a better understanding of your condition.

Information and Instructions About Your Examination

I understand that I am here for an Independent Medical or Impairment Examination (IME); this means the doctor performing the evaluation is neither treating me nor an employee of whomever requested the IME (insurance company, third party administrator, attorney, governmental agency, employer, or physician). The purpose of the IME is to provide a thorough, objective evaluation of the specific condition(s) related to the injury or illness in question as well as prior or subsequent conditions that may affect it and answer whatever questions the requesting party has. This document outlines the IME process, my rights, and my responsibilities.

This IME is not a comprehensive medical examination. It will not provide advice or treatment or substitute for evaluation or treatment by my regular treating doctor. A patient-physician relationship is not established between the evaluating physician and me. Accordingly, there is no patient/physician privilege associated with this evaluation. Usually a written report will be prepared summarizing today's evaluation and sent to the requesting party. If I would like a copy of the report, I will contact them.

I understand my evaluation will begin with the doctor obtaining a history of how my problem began and what evaluation or treatment has been rendered since. The doctor will also utilize information I provide verbally and documented on the history forms, as well as that contained within whatever records may be available for review. The doctor will then ask about my current symptoms and generally record a relatively brief past medical history and other information such as my work status, etc. All information I provide may be included in the report.

After the interview, a physical examination of the relevant body part(s) will be conducted. I understand that I need not perform any maneuver I feel might cause injury or a worsening of my symptoms and will immediately inform the examiner if anything he is doing is causing excessive discomfort so it can be stopped right away. Some pain, stiffness, or other symptoms are produced in most physical examinations of this sort, for instance when touching a tender spot or checking how far a stiff joint can move, and such findings are helpful in understanding my condition. The IME, however, is not intended to cause injury or excessive pain. I understand that in order to avoid that, I must fulfill my responsibility to inform the doctor if there is something I can't do or if a certain test is causing too much discomfort, etc.

I also understand that I am permitted to have a chaperone present during the physical examination, at my request. I consent to the taking of digital photographs to document findings during the physical examination.

I have read and understand the aforementioned information and instructions. I authorize this physician or any co-examiner to obtain any information that may be of relevance to the condition(s) in question and to release that information and results of this IME, verbally or in writing, to the entity that has requested the IME.

Signature____ Date_____________

Printed Name______________________________________

New Patient Questionnaire:

HISTORY OF PRESENT INJURY:

Describe how injury happened

What were your specific job duties (ONLY FOR WORKMAN'S COMP CLAIM)?

- **Did you have any days off from work due to the injury? Please list number of days/weeks/months.**

- **What date did you return to work?**

Right/Left Handed: ______________

Current Chief Complaint:

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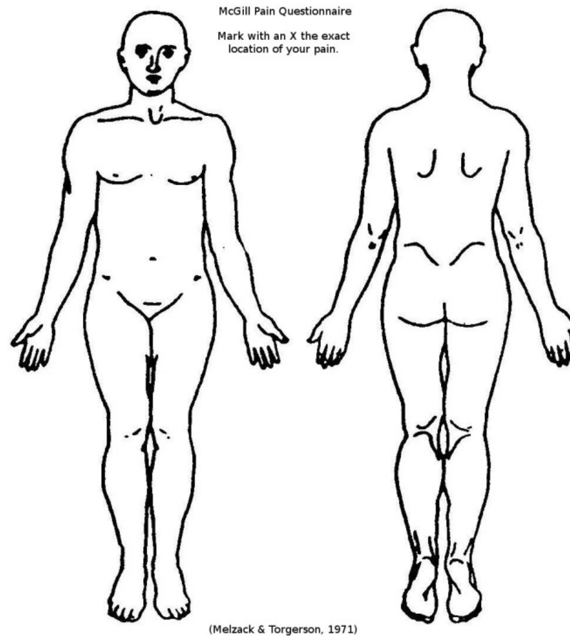
Where is your pain:

Please mark on the diagram where you feel pain right now. Use the key below:

KEY:
Pins & Needles = OOO
Stabbing Pain = ///
Burning = xxx
Deep Aches = zzz



Rate your pain: **No Pain= 0 1 2 3 4 5 6 7 8 9 10 =Emergency Room Pain**

What makes it better?

___

___

Describe the pain (circle all that apply):

Dull Sharp Aching Stabbing Burning Shooting Tingling Numbness

How does the pain change with: Worse(W) Better(B) No Change (NC)

Sitting_____ Standing_____ Walking____ Bending____

Twisting_____ Coughing_____ Sneezing_____

Brief Description of Job History:

Place of Employment	*Years Employed*	*Position/Job duties*

Please list any job/home tasks that are difficult for you to perform:

___

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What is your current work status?

- ☐Working full-time
- ☐Working part-time
- ☐Unemployed—disabled
- ☐Unemployed—not disabled
- ☐Retired
- ☐Homemaker
- ☐Student
- ☐Other
- ☐Work restrictions:

___

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Are you unemployed/underemployed because of your pain? Yes No

Previous Injuries:			
Year of Injury	**Body Part Affected**	**How Injury Happened**	**Was this work related?**

Previous Surgeries:			
Year of Surgery	**Body Part Affected**	**Procedure**	**Was this work related?**

Have you ever been diagnosed with the following?		
Condition:	***Check if yes***	***If yes, please explain:***
Asthma		
Depression		
Pneumonia		
High Blood Pressure		
Arthritis		
Fibromyalgia		
Cancer		
Psychiatric Disorder		
Stroke		
Headaches		
Diabetes		
Other		

Social History:

Marital Status: Single Married Widow Divorced
Number of children: ____________

Do you smoke cigarettes? Yes No
If yes, how many packs a day? _______________

Do you drink alcohol (beer, wine, etc.)? Yes No
If so, what type, how often, and amount:

____

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Do you or have you ever used recreational drugs? Yes No
If yes, what kind and how often:

____

____

What is your highest level of education?

☐Middle School/Elementary
☐High School
☐Some College
☐Associates Degree
☐Bachelor's Degree
☐Master's Degree
☐Doctorate Degree

Please list hobbies and things you enjoy doing:

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Present Treating Provider (May include Doctor, Nurse Practitioner, Physician's Assistant, Physical Therapy, Chiropractor, Individual Counseling, etc.)	
Provider Name	
Specialty	
Address	
Phone Number	
How often are you seen by this provider?	
Date last seen by this provider?	
Present Treating Provider	
Provider Name	
Specialty	
Address	
Phone Number	
How often are you seen by this provider?	
Date last seen by this provider?	
Present Treating Provider	
Provider Name	
Specialty	
Address	
Phone Number	
How often are you seen by this doctor?	
Date last seen by this provider?	

Present Treating Provider	
Provider Name	
Specialty	
Address	
Phone Number	
How often are you seen by this doctor?	
Date last seen by this provider?	

Current Prescribed and Over the Counter Medications

Medication	*Strength*	*How many do you take and when?*	*Who prescribes this medication?*	*How much does this medication cost you monthly?*

Allergies: Please list all allergies including medicines

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____
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Aids for Independent Functioning/Assistive Devices (Cane, Walker, Reacher, etc.) and Other Equipment (Wheelchair, Bath Chair, Lifts):				
Equipment	***Dealer/Where Purchased***	***Purchase Date***	***Purchase Price***	***Who prescribed or recommended this?***

Sleep:	
What time to you wake up?	
What time do you go to bed?	
About, how many hours a night do you sleep?	
Do you have difficulty falling asleep?	
Do you have difficulty staying asleep?	

Abilities:

Activity	*Yes*	*No*	*With Assistance*	*Comment*
Dress Self				
Bathe Self				
Feed Self				
Meal Preparation				
Cooking				
Laundry				
Pay Bills				
Use a Computer				
Shop				
Yard Work				
Clean the House				
Drive				
Hold a Job				
Use the Telephone				
Other				

Questions Concerning Activities of Daily Living
(**Check what applies to you**)

1. How well can you lift and carry?

- I can lift and carry heavy objects without extra discomfort.
- I can lift and carry heavy objects but get extra discomfort.
- I can lift and carry heavy objects.
- I can lift and carry light to medium objects.
- I can only lift very light objects.
- I cannot lift or carry anything at all.

2. How well can you push or pull (even with some pain or discomfort)?

- I can push or pull very heavy objects.
- I can push or pull heavy objects.
- I can push or pull light objects.
- I can push or pull very light objects.
- I cannot push or pull anything.

3. How well can you reach and grasp something off a shelf at chest level?

- No difficulty (and you can easily perform the activity).
- Some difficulty (but you can still perform the activity).
- A lot of difficulty (but you can still perform the activity).
- Unable (you cannot do this activity at all).

4. How well can you reach and grasp something off a shelf overhead?

- No difficulty (and you can easily perform the activity).
- Some difficulty (but you can still perform the activity).
- A lot of difficulty (but you can still perform the activity).
- Unable (you cannot do this activity at all).

5. Do you have any difficulty with gripping, grasping, holding and manipulating objects with your hands?

- No difficulty (and you can easily perform the activity).
- Some difficulty (but you can still perform the activity).
- A lot of difficulty (but you can still perform the activity).
- Unable (you cannot do this activity).

6. Do you have any difficulty with repetitive motions such as typing on a computer?

- No difficulty (and you can easily perform the activity).
- Some difficulty (but you can still perform the activity).
- A lot of difficulty (but you can still perform the activity).
- Unable (you cannot do this activity).

7. Do you have any difficulty with forceful activities with your arms and hands?

- No difficulty (and you can easily perform the activity).
- Some difficulty (but you can still perform the activity).
- A lot of difficulty (but you can still perform the activity).
- Unable (you cannot do this activity).

8. Do you have any difficulty with kneeling bending or squatting?

- No difficulty (and you can easily perform the activity).
- Some difficulty (but you can still perform the activity).
- A lot of difficulty (but you can still perform the activity).
- Unable (you cannot do this activity).

9. How well can you climb one flight of stairs?

- No difficulty (and you can easily perform the activity).
- Some difficulty (but you can still perform the activity).
- A lot of difficulty (but you can still perform the activity).
- Cannot climb one flight of stairs.

10. How well can you walk? (you may check more than one box)

- There is no change from before my Injury.
- Symptoms prevent me from walking more than 1 mile.
- Symptoms prevent me from walking more than ½ mile.
- Symptoms prevent me from walking more than ¼ mile.
- I walk only short distances.
- I use a cane, crutches or walker.
- I am limited to use of a wheelchair.

11. How well can you stand or walk for a period of time (even with some pain or discomfort) before you absolutely have to sit or lay down?

- I can stand/walk without any time limitations.
- I can only stand/walk between 1 hour and 2 hours at a time.
- I can only stand/walk between 30 and 60 minutes at a time.
- I can only stand/walk between 15 and 30 minutes at a time.
- I can only stand/walk for less than 15 minutes at a time.
- I cannot stand or walk at all.

12. How well can you sit for a period of time (even with some pain or discomfort) before you absolutely have to stand, walk or lay down?

- I can sit without any time limitations.
- I can only sit between 1 hour and 2 hours at a time.
- I can only sit between 30 and 60 minutes at a time.
- I can only sit between 15 and 30 minutes at a time.
- I can only sit for less than 15 minutes at a time.
- I cannot sit at all.

13. What is the most strenuous level of activity that you can do for at least 2 minutes?

- Very heavy activity.
- Heavy activity.
- Moderate activity.
- Light activity.
- Very light activity.
- Extremely light to no activity.

14. How well can you perform personal self–care activities including washing, dressing, using the bathroom, etc.

- I can look after myself normally without extra discomfort.
- I can look after myself normally but have extra discomfort.
- Self–care activities are uncomfortable and are done slowly.
- I manage most of my personal self–care with some help.
- I need a lot of help daily in most aspects of my self–care.
- I cannot perform self–care activities.

15. Do you have any difficulty with sleeping?

- I have no trouble sleeping because of my injury.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless.
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (6-7 hours sleepless).

16. In regards to sexual function (orgasm, ejaculation, lubrication, erection) changes since and because of your injury.

- There has not been a change because of my injury.
- There has been a slight change because of my injury.
- There has been a moderate change because of my injury.
- There has been a major change because of my injury.
- No sexual functioning because of my injury.

17. How much does your injury and/or pain interfere with your ability to travel?

- None.
- Some or a little of the time.
- A lot or most of the time.
- All of the time – can’t travel.

18. How much does your injury and/or pain interfere with your ability to engage in social activities?

- None.
- Some or a little of the time.
- A lot or most of the time.
- All of the time – I can't engage in social activities.

19. How much does your injury and/or pain interfere with your ability to engage in recreational activities?

- None.
- Some or a little of the time.
- A lot or most of the time.
- All of the time – I can't engage in recreational activities.

20. How much dos your injury and/or pain interfere with concentrating and thinking?

- None.
- Some or a little of the time.
- A lot or most of the time.
- All of the time – I can't concentrate or think very clearly.

21. How much has your injury and/or pain caused emotional distress with depression or anxiety?

- None.
- Some or a little of the time.
- A lot or most of the time.
- All of the time (severe depression or anxiety).

22. Have there been any changes in your ability to communicate (writing, typing, seeing, hearing, speaking) since and because of your injury? Explain.

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23. In regards to your pain most of the time.

- I have no pain most of the time.
- My pain is mild most of the time.
- My pain is moderate most of the time.
- My pain is severe most of the time.
- My pain is the worst imaginable most of the time.

24. In regards to your pain at the moment.

- I have no pain at the moment.
- My pain is mild at the moment.
- My pain is moderate at the moment.
- My pain is severe at the moment.
- My pain is the worst imaginable at the moment.

25. If zero indicates "no pain" and ten indicates "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?

- What was your pain level on average during the past week (circle the appropriate number)?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Emergency Room pain

- What was your pain level at its worst during the past week (circle the appropriate number)?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Emergency Room pain

Anything Else We Need to Know:

Signature____**Date**_______________