Welcome

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

We pledge that we will be both thorough and impartial. 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 anyone else needs a copy of this report, it is best to obtain it directly from the organization requesting this evaluation.

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.

The following is additional information about the assessment today, our understanding about the IME, and our respective responsibilities.

After this is completed, we will review your history with you and perform an examination. Prior to leaving please complete the Satisfaction Survey.

Information and Instructions About Your Independent Medical Examination and Release of Information

I understand that,I am here for an Independent Medical Examination (IME) which means the doctor(s) 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 your regular treating doctor A patient-physician relationship is not established between the evaluating physician and myself 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 that generally my evaluation will begin with the doctor obtaining a history of how my problem began, and what evaluation or treatment has been rendered since; utilizing information I provide verbally, and document 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 your 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(s) 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(our staff only) 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

Independent Medical Evaluation Questionnaire

1. What is your full name?_____
2. What is your date of birth?_____
3. Are you? ☐ Right handed ☐ Left handed ☐ Either
4. What is the date of your injury?
5. Have you ever had any previous problems or injuries, including any other work, recreational, or motor vehicle injuries? ☐ Yes ☐ No ☐ Not sure

   If yes, please describe:_____
   _____
   _____

6. Have you ever had any difficulties prior to the date of your injury which were similar to those you are now experiencing? ☐ Yes ☐ No ☐ Not sure

   If yes, please describe:_____
   _____
   _____

7. Please describe how your injury occurred:_____
   _____
   _____

8. What problems did you have at that time?_____
   _____
   _____

9. What did you do following the injury?_____
   _____

10. Have you had any additional injuries since the date of injury in question #4?_____
    _____

11. What is your greatest concern at this time?_____
    _____

If you are not having difficulty with pain, proceed to question 18.

12. Where is your pain located?_____

_____

13. How would you describe your pain (ache, burn, sharp, etc.)?_____

14. What makes your pain worse?_____

_____

15. What makes your pain better?)_____

_____

16. How frequent is your pain?

- ❑ Constant (present ¾ to all of the time)
- ❑ Frequent (present ½ to ¾ of the time)
- ❑ Occasional (present ¼ to ½ of the time)
- ❑ Intermittent (present less than ¼ of the time)

17. On a scale from 0 (no pain) to 10 (excruciating pain),

	No pain ← → Excruciating									
a. What number would you put on your pain at this time?	1	2	3	4	5	6	7	8	9	10
b. During the past month, what has it averaged?	1	2	3	4	5	6	7	8	9	10
c. During the past month, what is the highest it has been?	1	2	3	4	5	6	7	8	9	10
d. During the past month, what it the lowest it has been?	1	2	3	4	5	6	7	8	9	10

18. Are you having any other difficulties (numbness, weakness, etc.)? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe the difficulties in detail._____

_____

_____

19. Are there any tasks difficult for you to perform? ❑ Yes ❑ No ❑ Not Sure

If yes,, please describe the tasks which are most difficult for you:_____

_____

_____

a. How much can you lift occasionally? _____lbs.

b. Can you lift a gallon of milk? ❑ Yes ❑ No ❑ Not sure

c. Can you lift a heavy bag of groceries? ❑ Yes ❑ No ❑ Not sure

d. Can you lift a pail of water? ❑ Yes ❑ No ❑ Not sure

e. How long can you sit at one time? _____ Stand?_____ Walk?_____

20. Who were you employed by when you were injured?_____

21. How long had you been working there?_____

22. What was your job title?_____

23. What did this job involve?_____

_____

_____

24. What type of work have you performed previously?_____

25. Have you held any other jobs since your injury? ❑ Yes ❑ No

If yes, please describe:_____

26. What is your level of education?_____

27. Are you working now? ❑ Yes ❑ No

If yes, please describe your present job:_____

If no, when did you last work?_____

28. Has your doctor, or anyone, prescribed any work restrictions? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe these restrictions:_____

_____

_____

28. Where do you live?_____

29. Who lives with you?_____

30. Please describe your typical day:_____

31. Are you involved in any significant activities or recreational pursuits? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe:_____

In the past? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe:_____

32. Do you smoke? ❑ No ❑ Yes, in the past but I quit ❑ Yes, _____packs per day

32. How many alcoholic beverages do you have per week?_____

34. Have you had any medical (non-surgical) hospitalizations? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe:_____

_____

_____

35. Have you had any operations? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe:_____

_____

_____

36. Are you taking any prescribed medications? ❑ Yes ❑ No ❑ Not Sure

If yes, please list:_____

_____

_____

37. Are you allergic to any medication? ❑ Yes ❑ No ❑ Not Sure

If yes, please list:_____

_____

_____

38. Have you had any other medical problems? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe:_____

_____

_____

39. Do any diseases run in your family? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe:_____

_____

_____

40. Please provide any other comments which may assist us in understanding your situation:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for your assistance. At the time of the visit we will review this information in further detail.

Pain Drawing

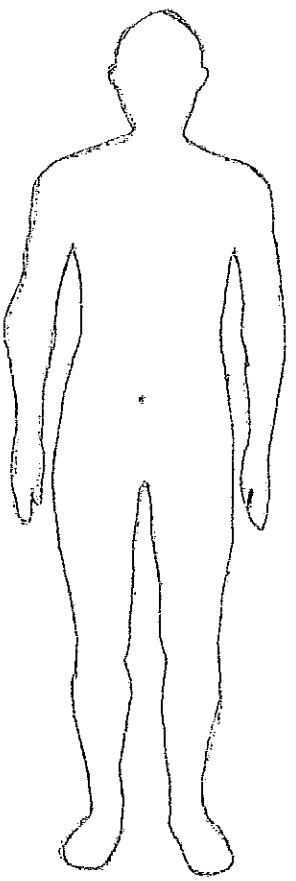
Name:_____ DATE:_____

WHERE IS YOUR PAIN NOW?

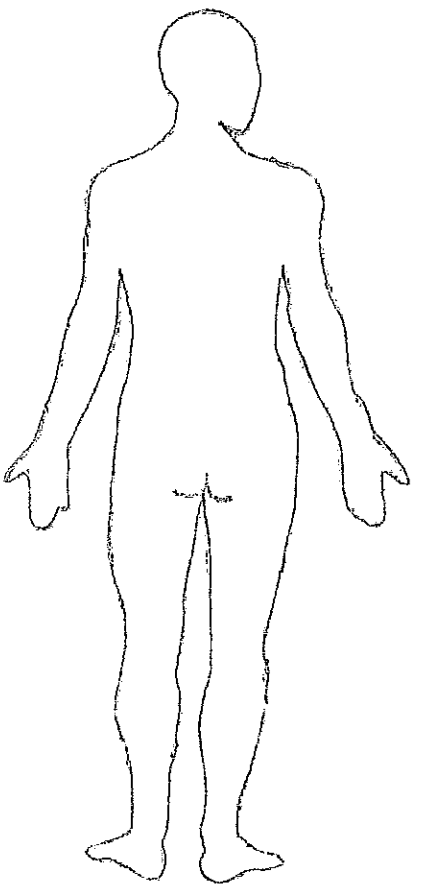
Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

SYMBOLS					
Aching	Numbness	Pins and Needles	Burning	Stabbing	Other
▲▲▲	= = =	OOO	XXX	///	***

FRONT VIEW



BACK VIEW



Name: _____ Date: _____

SHORT-FORM MCGILL PAIN QUESTIONNAIRE

Instructions: For each word which describes your pain, rate the intensity of that particular quality of pain.

	(0) None	(1) Mild	(2) Moderate	(3) Severe
1. Throbbing	☐	☐	☐	☐
2. Shooting	☐	☐	☐	☐
3. Stabbing	☐	☐	☐	☐
4. Sharp	☐	☐	☐	☐
5. Cramping	☐	☐	☐	☐
6. Gnawing	☐	☐	☐	☐
7. Hot-burning	☐	☐	☐	☐
8. Aching	☐	☐	☐	☐
9. Heavy	☐	☐	☐	☐
10. Tender	☐	☐	☐	☐
11. Splitting	☐	☐	☐	☐
12. Tiring-exhausting	☐	☐	☐	☐
13. Sickening	☐	☐	☐	☐
14. Fearful	☐	☐	☐	☐
15. Punishing-cruel	☐	☐	☐	☐

Rate the intensity of your pain overall: ☐ 0. No pain ☐ 1. Mild ☐ 2. Discomfort ☐ 3. Distressing ☐ 4. Horrible ☐ 5. Excruciating

On the following line indicate the intensity of your pain overall:

No pain _____ Worst possible pain

Pain Disability Index

Instructions: The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain on your life, not just when the pain is at its worst.

For each category, please circle the number that describes the levels of disability you typically experience. A score of 0 (zero) means no disability at all and a score of 10 (ten) means that all the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

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1. **Family / home responsibilities.** Activities related to the home, or family, including chores and duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).

No disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

2. **Recreation**. Hobbies, sports, and similar leisure time activities.

No disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

3. **Social Activity.** Participation with friends and acquaintances other than family members, including parties, theater, concerts, dining out, and other social functions.

No disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

4. **Occupation.** Activities that are a part of or directly related to one's job, including nonpaying jobs such as that of a homemaker or volunteer work.

No disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

5. **Sexual Activity.** This category refers to the frequency and quality of one's sex life.

No disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

6. **Self-care.** Activities of daily maintenance and independent daily living (taking a shower, driving, getting dresses).

No disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

7. **Life-support activities**. Basic life-support behaviors such as eating, sleeping, and breathing.

No disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

CES-D

Instructions: Using the scale below, indicate the number that best describes how often you felt or behaved this way DURING THE PAST WEEK.

FREQUENCY SCALE:

0 – Rarely or none of the time (less than 1 day)

1 – Some or a little of the time (1 - 2 days)

2 – Occasionally or a moderate amount of time (3- 4 days)

3 – Most or all of the time (5 –7 days)

_____ 1. I was bothered by things that usually don't bother me.

_____ 2. I did not feel like eating, my appetite was poor.

_____ 3. I felt that I could not shake off the blues even with help from my family or friends.

_____ 4. I felt that I was just as good as other people.

_____ 5. I had trouble keeping my mind on what I was doing.

_____ 6. I felt depressed.

_____ 7. I felt that everything I did was an effort.

_____ 8. I felt hopeful about the future.

_____ 9. I thought my life had been a failure.

_____ 10. I felt fearful.

_____ 11. My sleep was restless.

_____ 12. I was happy.

_____ 13. I talked less than usual.

_____ 14. I felt lonely.

_____ 15. People were unfriendly.

_____ 16. I enjoyed life.

_____ 17. I had crying spells

_____ 18. I felt sad.

_____ 19. I felt that people disliked me.

_____ 20. I could not get "going"

Oswestry Pain Index

Complete the following ONLY if you have back or neck pain.

Instructions: Please circle the one answer in each section that best applies to your condition.

A. Pain Intensity
- ❑ 0. Can tolerate the pain I have without having to use pain killers.
- ❑ 1. The pain is bad, but I manage without taking pain killers.
- ❑ 2. Pain killers give complete relief from pain.
- ❑ 3. Pain killers give moderate relief from pain.
- ❑ 4. Pain killers give very little relief from pain
- ❑ 5. Pain killers have no effect on the pain, and I do not use them.

B. Personal Care (Washing, dressing, etc.)
- ❑ 0. I can look after myself normally without causing extra pain.
- ❑ 1. I can look after myself normally, but it causes extra pain.
- ❑ 2. It is painful to look after myself, and I am slow and careful.
- ❑ 3. I need some help, but manage most of my personal care.
- ❑ 4. I need some help every day in most aspects of self care.
- ❑ 5. I do not get dressed, wash with difficulty, and stay in bed.

C. Lifting
- ❑ 0. I can lift heavy weights without extra pain.
- ❑ 1. I can lift heavy weights but it gives me extra pain.
- ❑ 2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned; e.g. on a table.
- ❑ 3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ 4. I can only lift very light weights.
- ❑ 5. cannot lift or carry anything at all.

D. Walking
- ❑ 0. Pain does not prevent me walking any distance.
- ❑ 1. Pain prevents me from walking more than 1 mile.
- ❑ 2. Pain prevents me from walking more than ½ mile.
- ❑ 3. Pain prevents me from walking more than ¼ mile.
- ❑ 4. I can only walk using a stick or crutches.
- ❑ 5. I am in bed most of the time and have to crawl to the toilet.

E. Sitting
- ❑ 0. I can sit in any chair as long as I like.
- ❑ 1. I can only sit in my favorite chair as ling as I like.
- ❑ 2. Pain prevents me from sitting more than 1 hour.
- ❑ 3. Pain prevents me from sitting more than ½ hour.
- ❑ 4. Pain prevents me from sitting more than 10 minutes.
- ❑ 5. Pain prevents me from sitting at all.

F. Standing

- ☐ 0. I can stand as long as I want without extra pain.
- ☐ 1. I can stand as long as I want, but it gives me extra pain.
- ☐ 2. Pain prevents me from standing for more than 1 hour.
- ☐ 3. Pain prevents me from standing for more than 30 minutes.
- ☐ 4. Pain prevents me from standing for more than 10 minutes.
- ☐ 5. Pain prevents me from standing at all.

G. Sleeping

- ☐ 0. Pain does not prevent me from sleeping well.
- ☐ 1. I can sleep well only using tablets.
- ☐ 2. Even when I take tablets, I have less than 6 hours of sleep.
- ☐ 3. Even when I take tablets, I have less than 4 hour of sleep.
- ☐ 4. Even when I take tablets, I have less than 2 hours of sleep.
- ☐ 5. Pain prevents me from sleeping at all.

H. Sex Life

- ☐ 0. My sex life is normal and causes no extra pain.
- ☐ 1. My sex life is normal, but causes some extra pain.
- ☐ 2. My sex life is nearly normal, but is very painful.
- ☐ 3. My sex life is severely restricted by pain.
- ☐ 4. My sex life is nearly absent because of pain.
- ☐ 5. Pain prevents any sex life at all.

I. Social Life

- ☐ 0. My social life is normal and gives me no extra pain.
- ☐ 1. May social life is normal, but increases the degree of pain.
- ☐ 2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ 3. Pain has restricted my social life, and I do not go out often.
- ☐ 4. Pain has restricted my social life to my home.
- ☐ 5. I have no social life because of pain.

J. Traveling

- ☐ 0. I can travel anywhere without extra pain.
- ☐ 1. I can travel anywhere but it gives me extra pain.
- ☐ 2. Pain is bad, but I manage journeys over 2 hours.
- ☐ 3. Pain restricts me to journeys of less than one hour.
- ☐ 4. Pain restricts me to short necessary journeys less than 30 minutes.
- ☐ 5. Pain prevents me from traveling except to the doctor or hospital.