Claimant Questionnaire Samples

INITIAL EVALUATION QUESTIONAIRE

Today's Date: Name: _____

Address: DOB: _____ Age: _____ Sex: _____

Height: _____ Weight: _____ Eye Color: _____

Phone #: _____ Hair Color: _____ Right Handed ____ Left Handed _____

Job Title: Date of Injury: _____ Employer: _____

Legal Representative: _____

- I understand and acknowledge the following:
  - I. This Independent Medical Examination is solely for evaluation purposes as requested by a third party and is directed only to the injuries sustained in conjunction with this claim.
  - II. This evaluation does not include or constitute any form of treatment or medical care and no patient/physician and/ or confidentiality relationships exist.

SIGNED: _____ DATE: _____

PLEASE ANSWER EACH QUESTION AS IT PERTAINS TO YOU AND YOUR CURRENT CLAIM. ALL INFORMATION IS NECESSARY IN ORDER TO PROPERLY EVALUATE YOUR DISABILITY, THANK YOU.

HOW DID YOU ARRIVE AT THIS OFFICE TODAY? (PLEASE CIRCLE)
Private Auto, Bus, Train, Taxi, Other: _____

DID ANYONE ACCOMPANY YOU TO TODAY'S EVALUATION? YES OR NO

IF YES, WHO? _____

ARE YOU PRESENTLY WORKING? YES OR NO (PLEASE CIRCLE ONE)

IF "NO", WHEN WAS YOUR LAST DATE OF EMPLOYMENT? _____

DID YOU BRING ANY X-RAYS/MRI FILMS OR ANY DIAGNOSTIC TESTING? YES or NO?
IF "YES", PLEASE SPECIFY:

(1) HISTORY OF ACCIDENT/INJURY:(PLEASE GIVE A BRIEF BUT DETAILED SUMMARY OF ACCIDENT/INJURY INCLUDING INJURED BODY PARTS)

(2) WERE YOU **CUT** OR **BRUISED** AS A RESULT OF THE INJURY? IF "YES", WHERE?

_____

(3) DID YOU FRACTURE ANY BONES? YES or NO?
IF "YES", WHICH BONE (S) DID YOU FRACTURE? _____

(4) BY WHOM AND WHERE WERE YOU FIRST TREATED?
PRIVATE PHYSICIAN: _____
HOSPITAL: _____
WERE YOU SEEN IN THE ER DEPART.? YES___ NO _____
PLEASE, BRIEFLY DESCRIBE THE EMERGENCY TREATMENT YOU RECEIVED.

_____
_____
_____
_____

(5) WERE YOU TAKEN BY AMBULANCE TO THE HOSPITAL? YES OR NO

(6) WHAT WERE YOUR COMPLAINTS IMMEDIATELY FOLLOWING THE ACCIDENT/INJURY?

_____
_____

(7) PLEASE LIST THE NAMES OF ANY DOCTORS OR OTHER SOURCES TO WHOM YOU HAVE GONE TO FOR TREATMENT OF SYMPTOMS RELATED TO THE ACCIDENT/INJURY.

NAME OF DOCTOR	SPECIALTY	HOW OFTEN SEEN

(8) WHO IS CURRENTLY TREATING YOU FOR THIS ACCIDENT/INJURY?

_____

(9A) PLEASE LIST ANY MEDICATIONS PRESCRIBED TO YOU FOR YOUR INITIAL TREATMENT:

NAME OF MEDICATION	DOSAGE	HOW OFTEN TAKEN	PRESCRIBED BY DOCTOR

(9B) ARE YOU STILL TAKING THE ABOVE MEDICATIONS OR ANY OTHER PRESCRIBED MEDICATIONS? _____

_____

(10) DID YOU UNDERGO SURGERY AS A RESULT OF YOUR ACCIDENT? YES or NO
IF "YES", PLEASE DESCRIBE:

TYPE OF SURGERY	DOCTOR	DATE OF SURGERY

(11) WHAT TESTS HAVE YOU HAD TO DATE?

TYPE OF TEST	DATE	TEST RESULTS, IF KNOWN

(12) WHAT ARE YOUR CURRENT COMPLAINTS: (e.g. neck pain, numbness, swelling, etc..)

_____

_____

_____

_____

(13) WHAT TREATMENT ARE YOU CURENTLY RECEIVING?

	YES or NO	DOCTOR	HOW OFTEN
• PHYSCIAL THERAPY?			
• CHIROPRACTIC CARE?			
• NEUROLOGICAL CARE?			
• ORTHOPAEDIC CARE?			
• PSYCHIATRIC CARE?			
• HOME EXERCISE?			

(14) ARE YOU PRESENTLY AWAITING AUTHORIZATIONS FOR TESTING, SURGERY, OR CONTINUED TREATMENT? YES or NO

IF "YES", PLEASE SPECIFY: (authorization for MRI scan, physical therapy, etc….)

_____

_____

_____

(15) ARE YOU PRESENTLY USING A CANE, CRUTCHES, ARM SLING, NECK BRACE, ETC...? IF "YES", ARE YOU WEARING IT TO TODAY'S EXAMINATION? PLEASE SPECIFY: _____

_____

PAST MEDICAL HISTORY

(16) HAVE YOU EVER HAD ANY MEDICAL PROBLEMS IN THE PAST SUCH AS HIGH BLOOD PRESSURE, HEART DIEASE, DIABETES MELLITUS, ARTHRITIS, MIGRAINE HEADACHES, ASTHMA, OR ANY OTHER SIGNIFICANT MEDICAL PROBLEMS?
IF "YES", PLEASE SPECIFY:

(17) HAVE YOU EVER HAD SURGERY IN THE PAST? IF SO, WHAT TYPE OF SURGERY, WHICH HOSPITAL WAS IT PERFORMED AT, THE NAME OF THE DOCTOR WHO PERFORMED THE SURGERY, AND THE DATE THAT THE SURGERY WAS PERFORMED.

(18) HAVE YOU EVER BEEN HOSPITALIZED IN THE PAST FOR ANY REASON? IF YES WHEN AND FOR WHAT REASON.

(19) HAVE YOU EVER HAD AN ACCIDENT OR SYMPTOMS SIMILAR TO THIS ACCIDENT/INJURY IN THE PAST?

(20) HAVE YOU HAD ANOTHER ACCIDENT/INJURY OR DEVELOPED SIMILAR SYMPTOMS SINCE THE ACCIDENT DESCRIBED ABOVE?

THANK YOU FOR YOUR COOPERATION

WORKERS COMPENSATION QUESTIONNAIRE FORM

FULL NAME: _____ TODAY'S DATE: _____ DATE OF ACCIDENT: _____

DATE OF BIRTH: _____ AGE: _____ SEX: □ MALE □ FEMALE HEIGHT: _____ WEIGHT: _____

YOU ARE: □ RIGHT HANDED □ LEFT HANDED HAIR COLOR: _____ EYE COLOR: _____

CELL PHONE NUMBER: _____

ATTORNEY NAME: _____ CURRENT TREATING DOCTOR'S NAME: _____

IF YOU HAD SURGERY OR INJECTIONS IN THE LAST 6 WEEKS, SPEAK WITH RECEPTIONIST* *IMMEDIATELY

□ SURGERY □ INJECTION DATE:_____ BODY PART: _____

FEMALES ONLY: ARE YOU PREGNANT? □ YES □ NO IF YES, HOW MANY WEEKS? _____

WERE YOU PREGNANT AT THE TIME OF THE ACCIDENT? □ YES □ NO IF YES, HOW MANY WEEKS? _____

DID ANYONE ACCOMPANY YOU TO THIS EXAM? □ YES □ NO RELATION: _____ NAME:_____

DO YOU NEED A TRANSLATOR? □ YES □ NO IF YES, WHAT LANGUAGE DO YOU SPEAK? _____

HOW DID YOU GET TO THIS OFFICE? □ DROVE YOURSELF □ BUS □ TRAIN □ RELATIVE OTHER:_____

HOW DO YOU TRAVEL TO YOUR DOCTOR'S APPOINTMENTS? _____

TELL US ABOUT YOUR WORK-RELATED INJURY (FOR INJURIES THAT OCCURRED WHILE AT WORK/PLACE OF EMPLOYMENT)

NAME OF EMPLOYER AT THE TIME OF THE ABOVE-MENTIONED INJURY DATE? _____

WHAT CAUSED YOUR INJURY/HOW DID YOUR INJURY OCCUR? _____

_____

_____

WHAT BODY PARTS DID YOU INJURE? _____

DID YOU LOSE CONSCIOUSNESS? □ YES □ NO IF YES, HOW LONG? _____

DID YOU SUSTAIN ANY FRACTURES? □ YES □ NO IF YES, WHERE? _____

DID YOU SUSTAIN ANY CUTS THAT NEEDED STITCHES? □ YES □ NO

IF YES, WHERE ON YOUR BODY? _____ HOW MANY STITCHES WERE APPLIED? _____

DID YOU GO TO THE HOSPITAL? □ YES □ NO IF YES, WHICH HOSPITAL DID YOU GO TO? _____

WERE YOU SEEN IN THE EMERGENCY ROOM? □ YES □ NO
WERE YOU ADMITTED? □ YES □ NO IF YES, HOW LONG? _____

TELL US WHAT TYPE OF TREATMENT YOU RECEIVED AFTER THE ABOVE-MENTIONED ACCIDENT/INCIDENT.

DID YOU RECEIVE ANY TREATMENT? □ YES □ NO IF YES, CHECK ALL THAT APPLY:
□ PHYSICAL THERAPY □ CHIROPRACTIC □ ACUPUNCTURE □ MASSAGE THERAPY □ HEAT □ ICE □ TENS UNIT
HOW LONG AFTER THE ACCIDENT/INJURY DID YOU START TREATMENT? □ SAME DAY □ NEXT DAY 1 2 3 4 5 6 7 8 9 10 □ DAYS LATER □ WEEKS LATER □ ____ AFTER SURGERY □ OTHER: _____
HOW MANY TIMES A WEEK DID YOU INITIALLY RECEIVE TREATMENT? 1 2 3 4 5 6 7 TIMES PER WEEK
ARE THE TREATMENTS GIVING YOU TEMPORARY RELIEF, OR ARE YOU GETTING PROGRESSIVE IMPROVEMENT?
_____
HOW MANY TIMES A WEEK DO YOU **CURRENTLY** RECEIVE TREATMENT? 1 2 3 4 5 6 7 TIMES PER WEEK
□ NOT CURRENTLY RECEIVING TREATMENT
IF CURRENTLY NOT RECEIVING TREATMENT, WHAT WAS THE DATE OF LAST TREATMENT? _____

PLEASE LIST ALL DOCOTORS THAT YOU HAVE TREATED WITH SINCE THE ACCIDENT/INJURY

DOCTOR: _____ SPECIALTY: _____ LOCATION: _____
DOCTOR: _____ SPECIALTY: _____ LOCATION: _____
DOCTOR: _____ SPECIALTY: _____ LOCATION: _____

****WERE ANY SURGERIES PERFORMED OR INJECTIONS GIVEN DUE TO THE ABOVE-MENTIONED ACCIDENT/INJURY****

□ YES □ NO
DATE OF SURGERY: _____ WHICH BODY PART? _____
DATE OF INJECTION: _____ WHICH BODY PART? _____

ANY PENDING OR SCHEDULED SURGERIES DUE TO THE ABOVE ACCIDENT/INJURY: □ YES □ NO IF YES, GIVE DETAILS:
DATE: _____ BODY PART: _____
ANY PENDING OR SCHEDULED INJECTIONS DUE TO THE ABOVE ACCIDENT/INJURY: □ YES □ NO IF YES, GIVE DETAILS:
DATE: _____ BODY PART: _____

PAST MEDICAL HISTORY. IN ORDER FOR US TO GET THE PROPER HISTORY, YOU MUST FILL OUT ALL THAT APPLIES

WERE YOU INVOLVED IN ANY ACCIDENT BEFORE THE ACCIDENT YOU ARE HERE FOR TODAY? □ YES □ NO
IF YES, DATES: _____
DID YOU SUSTAIN ANY INJURIES DUE TO THE ACCIDENT? □ YES □ NO
IF YES, TO WHERE _____

WERE YOU INVOLVED IN ANY ACCIDENT AFTER THE ACCIDENT YOU ARE HERE FOR TODAY? □ YES □ NO
IF YES, DATES: _____
DID YOU SUSTAIN ANY INJURIES DUE TO THE ACCIDENT? □ YES □ NO
IF YES, TO WHERE _____

WERE THE PREVIOUSLY SUSTAINED INJURIES SIMILAR TO THE INJURIES SUSTAINED IN THIS ACCIDENT/INCIDENT? □ YES □ NO

DID YOU UNDERGO ANY SURGERY NOT RELATED TO THE ACCIDENT YOU ARE HERE FOR TODAY? □ YES □ NO
IF YES, EXPLAIN:
_____
_____

DO YOU HAVE A HISTORY OF ANY SERIOUS ILLNESSES? □ DIABETES □ HIGH BLOOD PRESSURE □ ASTHMA □ OTHER _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS □ YES □ NO IF YES, PLEASE LIST NAME, DOSEAGE & FREQUENCY:_____
_____
_____

DO YOU HAVE ANY ALLERGIES?
_____

ACTIVITIES OF DAILY LIVING

HOW FAR CAN YOU WALK? □ NO LIMIT □ 1 MILE □ ½ MILE □ ¼ MILE □ 1 BLOCK OTHER: _____
HOW LONG CAN YOU STAND BEFORE YOU HAVE TO SIT? □ NO LIMIT □ 2 HOURS □ 1 HOUR □ 30 MINUTES □ 20 MINUTES
□ 10 MINUTES □ 5 MINUTES OTHER: _____
WHAT ACTIVITIES ARE YOU UNABLE TO DO BECAUSE OF YOUR INJURY?
□ GARDENING □ SPORTS □ DRIVING □ WASHING DISHES □ WASHING CLOTHES □ VACUUMING □ SWEEPING
□ TYING YOUR SHOES □ COOKING □ PERSONAL HYGEINE □ CHILDCARE NEEDS □ SHOPPING/RUNNING ERRANDS

WHAT ARE YOUR TYPICAL ACTIVITIES THROUGHOUT THE DAY AND/OR RECREATIONAL ACTIVITIES SINCE THE ACCIDENT?

_____
_____

DO YOU PARTICPATE IN ANY VOLUNTEER ACTIVITIES? □ YES □ NO ARE YOU PAID? □ YES □ NO
DO YOU SMOKE? □ YES □ NO
DO YOU CONSUME ALCOHOL? □ YES □ NO IF YES, HOW OFTEN? □ DAILY □ WEEKLY □ MONTHLY □ OCCASIONALLY □ OTHER

WORK HISTORY/SCHOOL HISTORY (PLEASE ANSWER THE QUESTIONS IN THIS SECTION, EVEN IF THIS INFORMATION IS APPROXIMATE)

WERE YOU EMPLOYED AT THE TIME OF THE ACCIDENT? □ YES □ NO □ FULL TIME □ PART TIME □ RETIRED
WHAT WAS YOUR OCCUPATION/JOB TITLE AT THE TIME OF THE ACCIDENT (BE SPECIFIC)? _____

_____
_____

WHAT DID YOUR DUTIES ENTAIL?
_____
DID YOU MISS ANY TIME FROM WORK? □ YES □ NO
IF YES, HOW LONG? _____
ARE YOU CURRENTLY WORKING? □ YES □ NO □ FULL TIME □ PART TIME □ SAME JOB □ NEW JOB
IF AT A NEW JOB, WHAT IS YOUR CURRENT OCCUPATION/JOB TITLE? _____
IF YOU ARE NOT CURRENTLY WORKING, IS IT BECAUSE OF THE ACCIDENT? □ YES □ NO
HAVE YOU WORKED IN ANY CAPACITY SINCE THE INJURY? _____
ARE YOU INTERESTED IN RETURNING TO WORK OR WORKING IN ANY CAPACITY? _____

CLAIMANT'S NAME _____

CLAIMANT'S SIGNATURE _____

DATE OF SIGNATURE _____