State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S IME QUESTIONNAIRE
under Section 137 WCL

WCB CASE NUMBER	CARRIER CASE NUMBER	DATE OF ACCIDENT	DATE OF EXAMINATION
CLAIMANT'S NAME AND ADDRESS		INSURANCE CARRIER'S NAME AND ADDRESS	

INSTRUCTIONS: Please complete this form to the best of your ability and recollection prior to the date of your Independent Medical Examination and **bring a copy of the questionnaire with you to the examination.** If you do not remember the answer to a question, please write this as your answer.

1. DATE OF BIRTH: _____

2. HISTORY OF INJURY/DISEASE (please provide a brief summary of how the injury or occupational condition occurred) _____
   _____
   _____

3. WHAT PART(S) OR AREA(S) OF THE BODY HAVE YOU FELT PAIN OR SYMPTOMS IN AS A RESULT OF THIS INJURY? _____
   _____
   _____

4. HAVE YOU LOST ANY TIME FROM WORK AS A RESULT OF THIS INJURY? YES NO

5. ARE YOU CURRENTLY WORKING IN ANY CAPACITY FOR ANY EMPLOYER OR IN SELF-EMPLOYMENT? (if yes please give details of current employment) _____
   _____
   _____

6. MEDICAL TREATMENT FOR THIS INJURY/OCCUPATIONAL CONDITION:

   A. WHERE WERE YOU FIRST TREATED? (e.g. on site, urgent-care, hospital, private physician) _____

B. CURRENT TREATING PHYSICIAN(s) (please provide names and addresses)
   1. _____
   2. _____
   3. _____
   4. _____

7. HAVE YOU HAD ANY TESTS AS A RESULT OF THIS INJURY? (please circle)
   X-ray CT scan MRI Ultrasound EMG/NCV (nerve conduction) Other

8. ARE YOU CURRENTLY TAKING ANY MEDICATIONS AS A RESULT OF THIS INJURY? (please list medication and dosage/frequency if known) _____
   _____
   _____
   _____

This form is completed to the best of my ability and recollection.

_____ _____
Signature Date