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Date of Examination	Location of Examination
Name Address Telephone	Social Security Number Age Height and Weight Date of Birth
Employer Name and Location **ON Date of Injury**	Which hand do you use to write with?
Injured Body Part (s):	Date of Injury:
Referring Physician (Last MD you saw)	Do you have an attorney? Name, address and Tel.

History of Present Illness

9. Describe the event(s) that took place that caused this injury? If an accident explain details. If from repetitive motion, explain what body part first was a problem, when and why you feel it is work related.
(Use the back of this sheet for more room.)

10. Describe when and what kind of treatment that you received immediately after the accident?
Who was the first MD you saw? Where? and When? Have you seen specialists?
Give dates and practitioner's name. *Have you had any tests?* MRIs? EMGs? Epidural injections, etc? What MD has most recently seen you? When did you last have physical therapy? (Please use other side if necessary)

Occupational History

11. What was the name and city and state of the business where this event occurred? **Please list the date of hire. Do you still work for this company? New Employer? What days and hours do you work ?**

12. What is/ was your job title and job description when this injury occurred?
What are/ were the routine tasks of the job? **If not the same, what are the routine tasks of your job now?**
How many pounds lifting and how often? Did you do bending, climbing, reaching?

13. Were you engaged in the routine tasks of your job when this injury took place?

14. Do you have a second job? What are the hours? Job description?

15. List your prior work history for 5 years.
Years, name of company, job title, brief job description. Did you have worker injury claims at these jobs?

Past Medical History

17. Have you had prior injuries to this body part ***or area of your body?***
Please describe. Include prior surgeries & dates & treatment. **List all other Medical Conditions. Family history?**

18. If you answered "yes" to the above question, had your problem resolved completely before the injury in question occurred? If not, describe your condition prior to the injury.

19. Current Medications (For ALL Conditions)

21. Allergies to medications?

22. Do you use alcohol, smoke, or recreational drugs?

Current Complaints/Status	
What are your current complaints? Do you have pain? If yes, describe what is the quality of pain, burning? Aching? Throbbing? What number 0-10 best describes your pain? How frequent is your pain?	25. Do you have pain at rest? In a seated position, standing position or while walking? Problems with sleeping? Daytime sleepiness? Headaches? Sexual dysfunction? Gastrointestinal distress? (Use reverse)
26. What activities make the pain worse?	27. What makes the pain better?
Current Activities	
28. What is the heaviest thing you lifted last week?	29. Do you drive? Did you drive today?
30. Do you have children at home? What ages? Marriage status?	31. Do you receive disability compensation?
32. List hobbies & daily activities?	
33. List your present treatment program? Include name/type of practitioners, how often per month? Physical therapy? Acupuncture? Chiropractor?	
34. What is your current job status? Please circle correct answer. a. Working normal duty b. Modified duty c. Out of work because no modified duty exists d. Totally disabled Please list dates that you were not working up until the present.	
35. Are you receiving any job retraining? Please describe.	
36. DO you have an attorney? Please list name, address and phone number.	

Pain (Self-report of Severity)

A. Rate how severe your pain is **right now, at this moment** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

No pain — Most severe pain can imagine

B. Rate how severe your pain is **at its worst** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

C. Rate how severe your pain is **on the average** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

D. Rate how much your pain is **aggravated by activity** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Activity does not aggravate pain — Excruciating following any activity

Sum score of Section I: A–D = Total pain severity/4 = _____

E. Rate how **frequently** you experience pain (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Rarely — All of the time

Add total pain severity score (items A–D/4) to score for item E = _____

Total pain severity score (range from 0 to 20) = _____

I. Activity Limitation or Interference

A. How much does your pain interfere with your ability to **walk 1 block**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to walk — Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of groceries)? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent from lifting 10 pounds — Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to sit for 1/2 hour — Impossible to sit for 1/2 hour

D. How much does your pain interfere with your ability to **stand for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Pain does not interfere with ability to stand at all — Unable to stand at all

E. How much does your pain interfere with your ability to **get enough sleep**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent me from sleeping — Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with social activities — Completely interferes with social activities

G. How much does your pain interfere with your ability to **travel up to 1 hour by car**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with ability to travel 1 hour by car — Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your **daily activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with my daily activities — Completely interferes with my daily activities

I. How much do you **limit your activities to prevent your pain from getting worse?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not limit activities — Completely limits activities

J. How much does your pain interfere with your **relationship with your family/partner/significant others?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with relationships — Completely interferes with relationships

K. How much does your pain interfere with your ability to do **jobs around your home?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely unable to do any job around home

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to shower or bathe without help

M. How much does your pain interfere with your ability to **write or type?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to write or type

N. How much does your pain interfere with your ability to **dress yourself?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to dress myself

O. How much does your pain interfere with your ability to **engage in sexual activities?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it almost impossible to engage in any sexual activity

P. How much does your pain interfere with your ability to **concentrate?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Never — All the time

Sum score of Section II:
A-P = Total score for activity limitation/16 =
Mean activity limitation = _____

III. Individual's Report of Effect of Pain on Mood

A. Rate your **overall mood** during the past week. (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Extremely high/good — Extremely low/bad

B. During the past week, how **anxious or worried** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

C. During the past week, how **depressed** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all depressed — Extremely depressed

D. During the past week, how **irritable** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all irritable — Extremely irritable

E. In general, how anxious/worried are you about performing activities because they **might make your pain/symptoms worse?**

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

Sum score of Section III:
A-E = Total pain impairment attributed to mood state/5 =
Mean score = _____