Patient Questionnaire

To be filled out by Patient at time of IME
(circle the appropriate answers)

Doctor'sName:_____
Specialty:_____
Location of Exam:_____
Date of Exam:_____

Patient's Name_____
Birth Date:_____ Sex: Male / Female
Height:_____ Weight:_____
Eye Color:_____ Are You: R / L Handed
Hair Color:_____ Date Of Accident:_____

Provided by: ***JurisSolutions, Inc.***
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Are You: Caucasian / Black / Hispanic / Asian / Indian / Other

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1. Date of Accident:_____
2. Type of Accident: Workers Compensation/Motor Vehicle/Other _____
3. Were you seat belted? Yes / No
A. Were you the Driver or Passenger? **B**. Were you Front seat / Back Seat?
4. Describe in detail how the accident/injuriesoccurred:_____
_____
5. What was injured?
_____
_____
6. Did you experience a loss of consciousness? Yes/No For How Long? _____
7. Did you sustain any bruises? Yes/No Where?_____
A. Any lacerations / cuts? Yes/No Where?_____
B. If yes, did you require stitches? Yes/No Where and how many?_____
8. Did you go to the emergency room? Yes/No
Where and When? _____
A. If so, did you go by ambulance?
_____
B. Were x-rays taken there?_____
C. If so, what was x-rayed and what were the results?_____
D. What type of treatment did you receive in the emergency room?_____
E. Were you admitted to the hospital? Yes/No For How Long?_____
9. Have you been re-hospitalized for these injuries? Yes/No
A. If so, where, when, and why?_____
_____
___
10. Has any further testing been done? Yes/No
What were the dates and results?
_____

_____
___

11. What, if any, studies have you brought with you to today's exam?_____
_____
____

12. What other doctors have you treated with as a result of the injuries that you have sustained?

Dr._____ Specialty _____

Date of first visit_____ Date of last visit_____

How often did you see this doctor_____

Currently_____

Type of treatment_____

Are you still seeing this doctor?_____

Dr._____

Specialty_____

Date of first visit_____ Date of last visit _____

How often did you see this doctor_____Currently_____

Type of treatment _____

Are you still seeing this doctor? _____

Dr._____ Specialty _____

Date of first visit_____ Date of last visit_____

How often did you see this doctor_____Currently _____

Type of treatment_____

Are you still seeing this doctor?_____

13. Are you currently receiving any type of treatment? Yes / No *(Circle One)*

A. If so, what type? Physical Therapy / Chiropractic / Medication / Ultrasound / (Circle One) Massage / Whirlpool / Ice / Heat / Acupuncture / Exercises

B. If other please explain: _____

C. How Often? _____

D. Please explain in detail

_____
_____
_____

14. What are your current symptoms / complaints?_____

15. Do you have any serious illnesses?_____

A. If so, what?

_____
_____
_____

16. Do you take any medication?_____

A. If so, what and what for?

_____

17. Have you ever had surgery?_____

A. If so, what and when?_____

18. Have you ever had a prior or subsequent similar injury, condition or accident?_____

A. If so , what and when?

_____
_____
_____

19. At the time of injury were you employed?Yes/No

Employer's Name_____

A. Full-time or part-time?_____

20. Did you lose time from work?Yes/No For How Long?_____

21. Have you worked in any capacity since your injury? Yes / No

A. If yes, doing what?_____

19. Are you currently working? Yes / No

A. Full-time or part-time?_____

Same job / New job *(Circle One)*

B. If yes, doing what?

_____

20. What type of daily activities do you engage in?

_____
_____
____

21. What do you do on a daily basis?

_____

I affirm that above information provided is true and correct to the best of my knowledge.
Patients
Signature:_____Date:_____