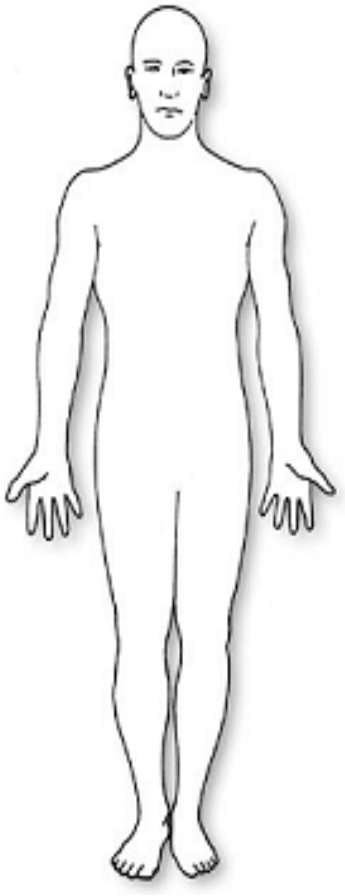
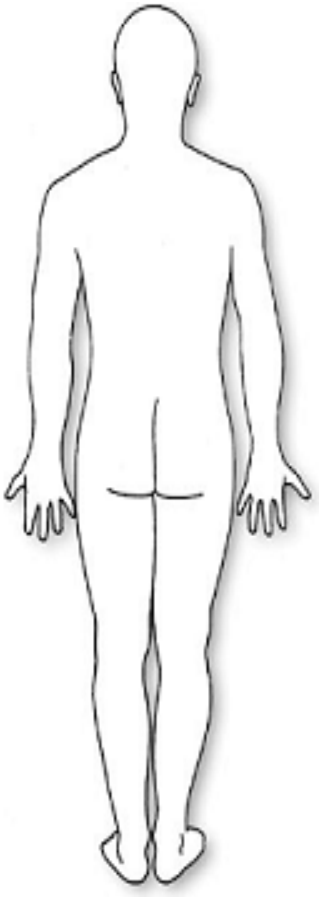
Date:_____ **Patient:**_____

Mark the area on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas. Mark how bad it is on the pain scale in the section below:

FRONT **BACK**





• • • • •	**Numbness**
oooooo	**Pins & Needles**
xxxxxx	**Burning Pain**
//////////	**Stabbing Pain**
vvvvvv	**Aching Pain**

Right **Left** **Left** **Right**

Use the following scale to indicate the severity of your pain:

None	Annoying	Uncomfortable	Dreadful	Horrible	Agonizing
0 1 2 3 4 5 6 7 8 9 10					
No pain	Mild Pain	Moderate Pain	Severe Pain	Very Severe Pain	Worst Possible Pain

HISTORY OF PRESENT ILLNESS

1. Please indicate how long you have had your present pain (circle one):

A. less then a month
B. 1 to 3 months
C. 3 to 6 months
D. 6 months to a year
E. more than a year

2. When did your present pain begin? (date)_____/_____/_____

3. Please indicate how you present pain began (circle one):

A. occurred during an athletic activity
B. occurred as a result of an auto accident
C. occurred while sitting
D. occurred while bending
E. occurred while lifting
F. occurred while working
G. unknown

4. What is the reason for today's visit? _____

5. Do you have any history of trauma? Yes_____ No_____

6. Is the injury work related? (check one)
Yes_____ No_____ Unsure_____

7. Is your current injury filed as a workers comp claim?
Yes_____ No_____ Unsure_____

8. Have you ever had a workers comp claim in the past?
Yes_____ No_____ Unsure_____

9. Using the following list of treatments, please indicate the effect of those that have been used in an attempt to heal your present injury:

	Helpful	Not Helpful	Duration of Effect
Back School			
Hot Packs			
Ice			
TENS Unit			
Traction			
Arching Exercises			
Sit Up Exercises			
Epidural Block			
Facet Block			
Ultrasound			
Other			

10. Please indicate if you have had any of the following studies:

	Yes / No	What facility were they taken at?
Regular x-ray of spine		
CT scan		
EMG		
Myelogram		
Discogram		
MRI		

11. Are you (check one): Employed_____ Student_____ Retired_____ Unemployed_____

If you answered "Unemployed" or "Employed", please answer the following questions:

A. How long have you been off work this year (circle one):

1. **No time**
2. **About 1 week**
3. **About 1 month**
4. **About 1 to 6 months**
5. **About 6 months to a year**

B. Are you presently working? Yes_____ No_____

If you answered "Yes", please complete the following:

1. **Length of employment: Years: _____ Months: _____**

If you answered "No", please complete the following:

1. **What was the date last worked:_____/_____/_____**
2. **Why are you no longer working? _____**
3. **If because of this problem, since what date have you been out of work?: _____**
4. **Is your job still available? Yes _____ No _____**

C. What is your job title? _____

D. Was your reason for leaving work due to a back or neck problem: Yes__ No_

12. Current source of income (circle all that apply):

1. **Spouse**
2. **Employer**
3. **Social security**
4. **Disability**
5. **Unemployment**
6. **Workers compensation**
7. **Other funds**
8. **Private earnings**

CURRENT PAIN PROFILE

13. How would you compare your pain ratio (check one)?

100% back pain to 0% leg pain	**100% back pain to 0% neck pain**	**100% neck pain to 0% arm pain**
75% back pain to 25% leg pain	**75% back pain to 25% neck pain**	**75% neck pain to 25% arm pain**
50% back pain to 50% leg pain	**50% back pain to 50% neck pain**	**50% neck pain to 50% arm pain**
25% back pain to 75% leg pain	**25% back pain to 75% neck pain**	**25% neck pain to 75% arm pain**
0% back pain to 100% leg pain	**0% back pain to 100% neck pain**	**0% neck pain to 100% arm pain**

14. Which of the following activities change the nature of your pain (check all that apply):

	Aggravates Pain	**Relieves Pain**	**Neither**
Sitting			
Standing			
Rising from sitting			
Leaning forward (brushing teeth)			
Walking			
Lying on your side			
Lying on your back			
Lying on your stomach			
Driving			
Coughing/Sneezing			
Bending forward			

Now go back and circle the boxes to indicate the most aggravating activity and the most relieving activity.

15. Please answer the following questions:

A. Unable to tolerate **_____How long can you sit?**
B. About 15 minutes only **_____How long can you stand?**
C. About 30 minutes only **_____How long can you walk?**
D. About 45 minutes
E. About 1 hour
F. Indefinite period

Approximate Height: _____ Approximate Weight:_____

MEDICATIONS

16. **Please list any prior medications you have tried for your spine and orthopedic problems that gave you no or minimal relief:** _____

_____

17. **Please list any prior medications you have tried for your spine and orthopedic problems that gave you significant relief:** _____

_____

18. **Please list any medications you are currently taking for your spine and orthopedic problems. If insurance approval is required for these medications, it will greatly help if you complete this form since the information you provide may be very beneficial in getting your medications approved. Please be as detailed as you can.**

Medication #1:

Name: _____ **Dose:** _____ **Frequency:** _____

How does this medication help your pain? _____

_____

If I take this medication, my pain level is _____ **on a scale from 0 to 10, with 0 being less pain and 10 being more pain. If I don't take this medication, my pain level is** _____ **on a scale from 0 to 10, with 0 being less pain and 10 being more pain.**

This medication helps me NOT AT ALL / A LITTLE / MODERATELY / A LOT / TREMENDOUSLY ***(circle one)***

How does this medication help you with function? Please list all ways that this medication helps you function. Following are some *examples* of things that medication can help with: sleeping, walking longer, sitting longer, keep you working, etc.: _____

_____

Please list any side effects you experience from this medication: _____

_____

Medication #2:

Name: _____ **Dose:** _____ **Frequency:** _____

How does this medication help your pain? _____

_____

If I take this medication, my pain level is _____ **on a scale from 0 to 10, with 0 being less pain and 10 being more pain. If I don't take this medication, my pain level is** _____ **on a scale from 0 to 10, with 0 being less pain and 10 being more pain.**

This medication helps me NOT AT ALL / A LITTLE / MODERATELY / A LOT / TREMENDOUSLY ***(circle one)***

How does this medication help you with function? Please list all ways that this medication helps you function. Following are some *examples* of things that medication can help with: sleeping, walking longer, sitting longer, keep you working, etc.: _____

_____

Please list any side effects you experience from this medication: _____

_____

Medication #3:

Name: _____ **Dose:** _____ **Frequency:** _____

How does this medication help your pain? _____

_____

If I take this medication, my pain level is _____ **on a scale from 0 to 10, with 0 being less pain and 10 being more pain. If I don't take this medication, my pain level is** _____ **on a scale from 0 to 10, with 0 being less pain and 10 being more pain.**

This medication helps me NOT AT ALL / A LITTLE / MODERATELY / A LOT / TREMENDOUSLY ***(circle one)***

How does this medication help you with function? Please list all ways that this medication helps you function. Following are some *examples* of things that medication can help with: sleeping, walking longer, sitting longer, keep you working, etc.: _____

_____

Please list any side effects you experience from this medication: _____

_____

Medication #4:

Name: _____ **Dose:** _____ **Frequency:** _____

How does this medication help your pain? _____

_____

If I take this medication, my pain level is _____ **on a scale from 0 to 10, with 0 being less pain and 10 being more pain. If I don't take this medication, my pain level is** _____ **on a scale from 0 to 10, with 0 being less pain and 10 being more pain.**

This medication helps me NOT AT ALL / A LITTLE / MODERATELY / A LOT / TREMENDOUSLY ***(circle one)***

How does this medication help you with function? Please list all ways that this medication helps you function. Following are some *examples* of things that medication can help with: sleeping, walking longer, sitting longer, keep you working, etc.: _____

_____

Please list any side effects you experience from this medication: _____

_____

Please list any medications you are currently taking that are unrelated to your spine and orthopedic problems: _____

_____

19. Do you have any allergies to medication? If so, please list the medication and explain the reaction:

_____

_____

Past Medical History

Have you had a history of:

Heart:

- □ High blood pressure
- □ High cholesterol
- □ Chest pain, tightness
- □ Shortness of breath with 2 flights of stairs
- □ Cardiac testing or seen a cardiologist within the past 5 years (Stress test, ECHO)
  - □ Was told results were abnormal
- □ Irregular heart beat or murmur (palpitations)
- □ Heart attack
- □ Heart failure
- □ Sleeps with 2 or more pillows due to shortness of breath when lying flat
- □ Pacemaker or defibrillator
- □ Other Cardiac Conditions: _____

Lung:

- □ Recent cough, cold or fever
- □ Asthma
- □ Emphysema/COPD
- □ Uses an inhaler
  - □ Daily
  - □ Few times per week
  - □ Few times per month
- □ Has had to go to the hospital for Asthma/COPD
  - □ Required a breathing tube
  - □ Required oral steroids (prednisone)
- □ PPD positive
  - □ Has been treated for TB
- □ Restrictive lung disease
- □ Obstructive sleep apnea
  - □ Uses CPAP or BIPAP at night
- □ Other Lung Problems: _____

Neurologic:

- □ Epilepsy/Seizures
- □ Migraines or frequent headaches
- □ History of Stroke or "mini stroke" (TIA)
  - □ Residual weakness, blindness, language problems
- □ Loss of consciousness or passing out
- □ Carotid Artery Stenosis
- □ Required neurologic testing (Carotid ultrasound, EMG, Head CT)
- □ Experiences numbness or weakness
  - □ Upper extremities
  - □ Lowe extremities
- □ Other Neurologic problems: _____

GI/Hepatic:

- □ Gastrointestinal reflux (GERD) or Heart Burn
  - □ Symptoms Daily
  - □ Well controlled
- □ Yellow jaundice
- □ Difficulty swallowing
- □ Bowel incontinence (uncontrolled loss of stool)
- □ Frequent constipation
- □ Frequent diarrhea
- □ Dark or bloody stool
- □ Pain with bowel
- □ Persistent/recurring belly pain
- □ AIDS/HIV
- □ Hepatitis (current or in the past)
  - □ A
  - □ B
  - □ C
- □ Liver Disease
  - □ Cirrhosis (□Alcoholic □Hepatitis related)
  - □ Other: _____

Kidney/GU:

- □ Urinary incontinence (loss of bladder control)
- □ Burning with urination
- □ Frequent Urination
- □ Bleeding with urination
- □ Diabetes
  - □ Insulin dependent
  - □ Oral meds
  - □ Diet controlled
- □ Kidney Disease
- □ Dialysis

Hematologic:

- □ Has been told by doctor that they bleed easily or have bleeding disorder
- □ Has had a blood clot
  - □ Leg
  - □ Arm
  - □ Lung
  - □ Required heparin or Coumadin (warfarin) treatment

Endocrine:

- □ Thyroid problems
  - □ Hypothyroid
  - □ Hyperthyroid
- □ Cancer – Type: _____
  - □ Chemo
  - □ Radiation
  - □ Surgery

Musculoskeletal:

□ Fever, chills, or sweats
□ Arthritis- Type and joints affected: _____
□ Neck pain
□ Back pain
□ Gout
□ Calf cramp with walking
□ Fibromyalgia
□ rash

HEENT:

□ Hoarseness
□ Dentures or partials
□ Loose tooth(teeth)
□ Infected tooth(teeth)
□ Hearing aids
□ Vision problems (Retinal vein/artery occlusion, cataracts, glaucoma, blindness)

Psychiatric:

□ Anxiety
□ Depression
□ Bipolar Disorder

□ _____

List all other major illnesses

Are you under a doctor's care for any medical condition? Yes____ No____

If yes, please explain: _____

Treatment History:

□ Orthopedic Surgeries:

1. Surgery: Date: Physician:
2. Surgery: Date: Physician:
3. Surgery: Date: Physician:

□ Spine Surgeries:

1. Surgery: Date: Physician:
2. Surgery: Date: Physician:
3. Surgery: Date: Physician:

□ Other Surgeries:

1. Surgery: Date: Physician:
2. Surgery: Date: Physician:
3. Surgery: Date: Physician:

Did you improve from your surgical procedure(s)?

Most recent surgery? Yes_____ No_____

□ **Have been told that there was trouble/difficulty with Anesthesia**:

□ Difficult Airway
□ Nausea/Vomiting
□ Allergic Reaction: _____

Procedures:
□ Injections:

1. Type: Date: Physician:
2. Type: Date: Physician:
3. Type: Date: Physician:

Alternate Treatment Modalities
□ Chiropractic Treatment:
_____ Visits, (*helpful/not helpful*)

□ Acupuncture Treatment:
1. Acupuncturist
_____ Visits, (*helpful/not helpful*)

□ Physical Therapy:
_____ Visits, (*helpful/not helpful*)

Family History
Has any family member (blood related) had any of the following? Please select each that apply:

□ Yes □ No Life-threatening reaction to anesthesia (malignant hyperthermia)?
□ Yes □ No Heart Attack before age 55?
□ Yes □ No Back pain?
□ Yes □ No Arthritis?
□ Yes □ No Tuberculosis
□ Yes □ No Migraine Headaches
□ Yes □ No Muscle or nerve disease? If so, what _____
□ Yes □ No Cancers? If so, what type _____
□ Yes □ No Any other disease which might affect your treatment? Please list: _____
_____

Social History
How much alcohol do you usually drink?

□ None
□ 1 to 2 drinks per week
□ 1 to 2 drinks per day
□ 3 to 5 drinks per day
□ more than 5 drinks per day

□ Yes □ No Have you been treated for drug or alcohol abuse? Please clarify: _____
_____
□ Yes □ No Do you use street drugs? If yes, what? _____
□ Yes □ No Have you been a cigarette smoker in the past 5 years?
□ Yes □ No Currently, do you smoke? If yes, how much per day? _____
How many years have you been smoking? _____

Are you: □ Single □ Separated □Married □Widowed □Divorced

Number of children, if any: _____

□ Yes □ No Is there any chance you are pregnant?

OSWESTRY FUNCTION TEST

Complete this form only if you have back or leg problems (Page 6 and 7).

20. Please answer the following questions by placing the number of the most applicable on the blank lines:

1. How long have you had back pain?

_____ About 1 week
_____ About 1 month
_____ About 3 months
_____ About 6 months
_____ About 1 year

2. How long have you had leg pain?

_____About 1 week
_____About 1 month
_____About 3 months
_____About 6 months
_____About 1 year

21. Please check the one answer in each section that best applies to your condition.

PAIN INTENSITY

	I can tolerate my pain without having to use painkillers.
	My pain is bad, but I can manage without taking painkillers.
	Painkillers give me complete relief from my pain.
	Painkillers give me moderate relief from my pain.
	Painkillers give me very little relief from my pain.
	Painkillers have no effect on my pain and I do not use them.

PERSONAL CARE (WASHING, DRESSING, ETC)

	I can look after myself normally without causing extra pain.
	I can look after myself normally, but causes extra pain.
	It is painful to look after myself and I am slow and careful.
	I need some help but I manage my personal care.
	I need every day in most aspects of self-care.
	I do not get dressed, wash with difficulty , and stay in bed.

LIFTING

	I can lift heavy objects without extra pain.
	I can lift heavy objects, but it gives me extra pain.
	Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned.
	Pain prevents me from lifting heavy objects, but I can manage light to medium objects if they are conveniently positioned.
	I can only lift very light objects.
	I cannot lift or carry anything at all.

WALKING

	Pain does not prevent me from walking any distance.
	Pain prevents me from walking more than a mile.
	Pain prevents me from walking more than ½ mile.
	Pain prevents me from walking more than ¼ mile.
	I can only walk using a cane or crutches.
	I am in bed most of the time and have to crawl to the toilet.

SITTING

	I can sit in my chair as long as I like.
	I can only sit in my favorite chair as long as I like.
	Pain prevents me from sitting more than 1 hour.
	Pain prevents me from sitting more than ½ hour.
	Pain prevents me from sitting more than 10 minutes.
	Pain prevents me from sitting at all.

STANDING

	I can stand as long as I want without extra pain.
	I can stand as long as I want, but it gives me extra pain.
	Pain prevents me from standing more than 1 hour.
	Pain prevents me from standing more than ½ hour.
	Pain prevents me from standing more than 10 minutes.
	Pain prevents me from standing at all.

SLEEPING

	Pain does not prevent me from sleeping well.
	I can sleep well only by taking medication for sleep.
	Even when I take medication I have less than 6 hours sleep.
	Even when I take medication I have less than 4 hours sleep.
	Even when I take medication I have less than 2 hours sleep.
	Pain prevents me from sleeping at all.

SEX LIFE

	My sex life is normal and causes me no extra pain.
	My sex life is normal and causes me some extra pain.
	My sex life is nearly normal, but is very painful.
	My sex life is severely restricted by pain.
	My sex life is nearly absent because of pain.
	Pain prevents any sex life at all.

SOCIAL LIFE

	My life social life is normal and causes me no extra pain.
	My social life is normal, but increases the degree of pain.
	Pain has no significant effect on my social life apart from limiting my more energetic interests like dancing, etc.
	Pain has restricted my social life and I do not go out as often.
	Pain has restricted my social life to my home.
	I have no social life because of pain.

TRAVEL

	I can travel anywhere without pain.
	I can travel anywhere but it gives me extra pain.
	Pain is bad, but I manage journeys over 2 hours.
	Pain restricts me to journeys of less than 1 hour.
	Pain restricts me to short necessary journeys under 1/2 hour.
	Pain prevents me from traveling except to the doctor or hospital.

Neck Disability Index. Complete this form only if you have neck or arm problems. This questionnaire has been designed to give your doctor information as to how your pain has affected you in your everyday life activities. Please answer each section; circle one letter, which best describes your status today.

Section 1-Pain Intensity

A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

Section 2-Personal Care (Washing, dressing, etc.)

A. I can look after myself normally without causing all. extra pain.
B. I can look after myself normally but it causes me extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some extra help but manage most of my personal care.
all.
E. I need help everyday on most aspects of self-care.
F. I do not get dressed, wash with difficulty and stay in bed.

Section 3-Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me extra with pain.
C. Pain prevents me from lifting heavy weights of off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are all. conveniently positioned.
E. I can only lift very lightweights.
F. I cannot lift or carry anything at all.

Section 4-Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want to with a slight pain in my neck.
C. I can read as much as I want to with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I can hardly read at all because of severe pain in my neck.
F. I cannot read at all.

Section 5-Headache

A. I have no headaches at all.

Section 6-Concentraion

A. I concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I wan to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I cannot concentrate at

Section 7-Work

A. I can do as much as I want to.
B. I can do my usual work but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do my work at

F. I cannot do any work at all.

Section 8-Driving

A. I can drive my car without any neck pain.
B. I can drive my car as long as I want to with slight pain in my neck.
C. I can drive my car as long as I want moderate pain in my neck.
D. I cannot drive my car as long as I want because moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at

Section 9-Sleeping

A. I have no trouble sleeping at all.
B. My sleep is slightly disturbed (less than 1 hour sleep loss).
C. My sleep is mildly disturbed (1-2 hour sleep loss).
D. My sleep is moderately disturbed (2-3 hour sleep loss).
E. My sleep is greatly disturbed (3-5 hour sleep loss).
F. My sleep is greatly disturbed (3-5 hour sleep loss).

Section 10-Recreation

A. I am able to engage in all my recreational activities with no neck pain at all.
B. I am able to engage in all my recreational activities with some pain in my neck.

B. **I have slight headaches, which come infrequently.**
C. **I have moderate headaches, which come infrequently.**
D. **I have moderate headaches, which come frequently.**
E. **I have severe headaches, which come frequently**
F. **I have headaches almost all the time.**

C. **I am able to engage in most but not all of my usual recreational activities because of my neck pain.**
D. **I am able to engage in few of my usual recreational activities because of pain in my neck.**
E. **I can hardly do any recreational activities because of my neck.**
F. **I cannot do any recreational activities.**

ACTIVITIES OF DAILY LIVING COMMONLY MEASURED IN ACTIVITIES OF DAILY LIVING (ADL)*

APPLICANT HAS DIFFICULTY WITH: MARK WITH AN "X" BELOW AND EXPLAIN WHERE INDICATED						
	Category of Activity	**Activity**	**Without Difficulty**	**With Some Difficulty**	**With Much Difficulty**	**Mostly Unable To Do**
1	**SELF CARE, PERSONAL HYGIENE:** Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating	**Shower**				
		Bath				
		Wash/Dry Body				
		Wash and Dry Face				
		Turn On/Off Faucets				
		Brush Teeth				
		Get On/Off Toilet				
		Comb/Brush Hair				
		Dress Self				
		Put On/Off Shoes/Socks				
		Open a Carton of Milk				
		Open a Jar				
		Lift Glass/Cup to Mouth				
		Make a Meal				
		Lift Fork/Spoon to Mouth				
		Describe other: bladder and bowel function difficulties, incontinence, retention, constipation?				

	Category of Activity	Activity	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable To Do
2	**PHYSICAL ACTIVITY**: Standing, sitting, reclining, walking, climbing stairs	**Stand**				
		Sit				
		Recline				
		Rise From a Chair				
		Get In/Out of Bed				
		Climb Flight of 10 Stairs				
		Work Outdoors				
		Light Housework				
		Shop/Do Errands				
		Carry Groceries				
		Lift 5 lbs.				
		Lift 10 lbs.				
		Lift 20 lbs.				
		Lift 30 lbs.				
		Walk				
		Care for Children or Parents				
		Engage in hobbies: music or crafts, etc. Indicate hobby				
		Describe other: eating/chewing difficulty: TMJ				

	Category of Activity	Activity	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable To Do
3	**COMMUNICATION** writing, typing, seeing, hearing, speaking	**Write a Note**				
		Type a Message on a Computer/Typewriter				
		See a Television Screen				
		Use a Telephone				
		Speak Clearly				
		Hear Clearly				
		Describe Others:				
4	**NONSPECIFIED HAND ACTIVITIES:** grasping, lifting, tactile, discrimination)	**Pick Up Small Items**				
		Turn a Knob on a Door				
		Write With a Pen/Pencil				
		Steer Wheel of Car				
		Describe Other:				

	Category of Activity	Activity	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable To Do
5	**SENSORY FUNCTION:** hearing, seeing, tactile feeling, tasting, smelling	**Feel What You Touch**				
		Taste What You Eat				
		Smell What You Eat				
		Describe Other:				
6	**TRAVEL:** riding, driving, flying	**Get In/Out of a Car**				
		Drive a Car				
		Ride in a Car				
		Fly in a Plane				
		Ride a Bicycle				
		Describe Other:				

	Category of Activity	Activity	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable To Do
7	**SEXUAL FUNCTION:** orgasm, ejaculation, lubrication, erection	**Engage in sexual activity**				
		Describe specific difficulty: Orgasm, ejaculation, lubrication, erection				
8	**SLEEP:** restful sleep, nocturnal sleep pattern	**Get to Sleep**				
		Sleep Through the Night				
		Have Restful Sleep				
		Feel Refreshed After Sleep				
		Describe Specific Difficulty: (teeth grinding at night, excessive daytime fatigue, irritability, etc.)				

***This chart is meant to assist the examining physician to place the Applicant in certain impairment categories when determining whole person impairment under the American Medical Association Guides to the Evaluation of Permanent Impairment (AMA) and in identifying body systems requiring referrals for Impairment evaluation.**

***Note: ADLS may indicate a serious condition requiring treatment.**

Cocchiarella, Linda, and B.J. Andersson Gunnar. Guides to the Evaluation of Permanent Impairment. Table 1-2: Activities of Daily Living. 5th Edition (2004). American Medical Association. 4.

EPWORTH SLEEPINESS SCALE

Patient Name: **Date**:

Please rate your likelihood of falling asleep in the following situations: (circle a number in each row)

	Never	Sometimes	Most Times	Always
Sitting and Reading	0	1	2	3
Watching Television	0	1	2	3
Sitting in a Public Place	0	1	2	3
Riding as a Passenger for 1 Hour	0	1	2	3
Lying Down to Rest in the Afternoon	0	1	2	3
Sitting and Talking to Someone	0	1	2	3
Sitting After a Non-Alcohol Lunch	0	1	2	3
Stopped in Traffic	0	1	2	3

TOTAL: _____/24

Patient Signature: _____

Class 1: 1%-9% impairment of the whole person. Reduced daytime alertness; sleep pattern such that individual can perform most activities of daily living.

Class 2: 10%-29% impairment of the whole person. Reduced daytime alertness. Interferes with ability to perform some activities of daily living.

Class 3: 30%-69% impairment of the whole person. Reduced daytime alertness; ability to perform activities of daily living significantly limited.

Class 4: 70%-90% impairment of the whole person. Reduced daytime alertness; individuals unable to care for self in any situations or manner.

Cocchiarella, Linda, and B.J. Andersson Gunnar. Guides to the Evaluation of Permanent Impairment. Table 13-4: Criteria for Rating Impairment Due to Sleep and Arousal Disorders. 5th Edition (2004). American Medical Association. 317.

INDIVIDUAL'S REPORT OF EFFECT OF PAIN ON MOOD

For each question below, circle the number which most accurately describes how your pain over the past week has affected your mood.

1. **Rate your overall mood during the past week .**										
0	1	2	3	4	5	6	7	8	9	10
Extremely High/Good										Extremely Low/Bad
2. **During the past week, how anxious or worried have you been because of your pain?**										
0	1	2	3	4	5	6	7	8	9	10
Not At All Anxious/Worried										Extremely Anxious/Worried
3. **During the past week, how depressed have you become because of your pain?**										
0	1	2	3	4	5	6	7	8	9	10
Not At All Depressed										Extremely Depressed
4. **During the past week, how irritable have you become because of your pain?**										
0	1	2	3	4	5	6	7	8	9	10
Not At All Irritable										Extremely Irritable
5. **In general, how anxious 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										Extremely Anxious

(For Physician Use Only) *(Para el Uso del Médico Solamente)*

Sum Score of 1-5: _____

Total Pain Impairment Attributed to Mood State/5= _____

Mean Score= _____

Cocchiarella, Linda, and B.J. Andersson Gunnar. Guides to the Evaluation of Permanent Impairment. Table 18-4: Ratings Determining Impairment Associated with Pain: Individual's Report of Effect of Pain on Mood. 5th Edition (2004). American Medical Association. 577.