PHYSICAL IMPAIRMENT QUESTIONNAIRE

CLIENT: _____ TELEPHONE: _____

ADDRESS: _____ SSN: _____

_____ DATE OF BIRTH: _____
AGE: _____

All of the questions in this questionnaire are important. Take your time and answer them all carefully and as accurately as possible.

MEDICAL INFORMATION:

1. Current Height (without shoes): ___ft.____in. Current Weight (without shoes):_____lbs.

   Your usual weight? _____lbs. When was the last time you weighed this much? _____

2. Do you smoke? ☐ Yes ☐ No If yes, how much? _____

3. Have you *ever* been treated by a psychiatrist or psychologist? ☐ Yes ☐ No

   If yes, give details including dates, reasons for treatment, and nature of treatment: _____

   _____

   Have you ever been prescribed medication for a psychological problem by a doctor even if not a psychologist or psychiatrist?
   ☐ Yes ☐ No What medication and doctor? _____

4. Have you *ever* had any problems with drug abuse? ☐ Yes ☐ No If yes, when? _____

   If yes, describe the problem: _____

   Have you recovered? ☐ Yes ☐ No If yes, when did you recover? _____

5. Have you *ever* been treated, including by attending Alcoholics Anonymous, for alcohol abuse (alcoholism)?

   ☐ Yes ☐ No

   a. If yes, when and where? _____

   b. Have you recovered from alcoholism. If yes, when did you recover? _____

6. ***CURRENT MEDICAL PROBLEMS*** List all current physical medical problems (use another sheet if you need to):

PHYSICAL MEDICAL PROBLEM	APPROXIMATELY WHEN DID IT START?	WHAT DOCTOR TREATS YOU FOR IT?

7. Since the date you became disabled, have you been getting better or worse? ☐ Better ☐ Worse ☐ Same

8. Will you ever get well enough to work again? ☐ Yes ☐ No If yes, when? _____

9. Has any doctor told you not to work? ☐ Yes ☐ No If yes, who? _____

10. Has any doctor told you to limit your activities? ☐ Yes ☐ No

    a. If yes, please describe the limitations: _____

    _____

    b. Which doctor(s) told you this? _____

11. Do you have a handicapped-parking permit? ☐ Yes ☐ No If yes, which doctor signed for it? _____

12. Which doctor knows you best? _____

13. Do you have any *current* problem with any of the following? ☐ Yes ☐ No. If yes, please circle them.

Shortness of breath	Coughing up blood	Hot/cold flashes	Vision	Drug abuse
Excessive sweating	Heart palpitations	Controlling your urine	Diarrhea	Fatigue
Alcohol abuse	High blood pressure	Difficulty sleeping	Blackouts	
Swelling of feet/ankles	Recent weight gain	Recent weight loss	Dizziness	

PAIN:

14. If your disability involves pain, answer the following: (**If pain is not your problem, go on to question 15.**)

    a. Approximate date pain began: _____

    b. What event caused the pain (e.g. accident, disease, surgery, unknown)? _____

    _____

    c. What does your pain feel like? _____

    _____

    d. What reasons have your doctors given for your pain? _____

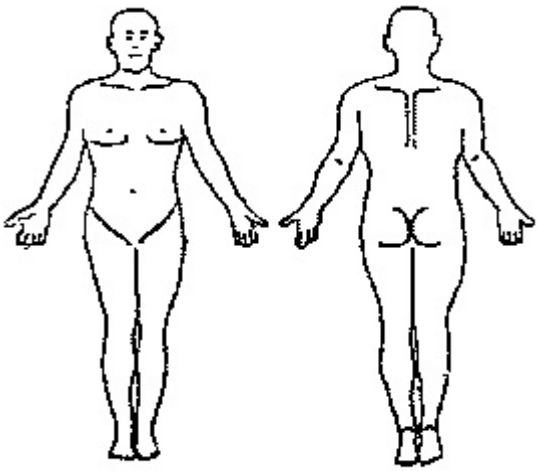
    _____

    e. Does pain decrease or increase when you push on the painful spots? ☐ decrease ☐ increase

    f. Are any of the following words associated with your pain? If so, please check next to those that apply.

	Numbness		Tingling (pins and needles)		Weakness
	Increased sweating		Muscle spasm		Skin discoloration
	Nausea		Loss of sleep		Crying spells
	Loss of concentration		Depression		Agitation

g. Location of pain: Please shade in areas of pain. ***BE AS SPECIFIC AS POSSIBLE.***



h. Is your pain: ☐ Constant? ☐ Often? ☐ Occasional?

i. How many **hours per day** do you have pain? _____

j. If you do not have pain every day, how many hours of pain per week, or days per week or month:

_____ hours per week _____ days per week _____days per month

k. Below is a list of activities. For each activity indicate with a checkmark how it affects your pain.

	INCREASES	**DECREASES**	**NO EFFECT**
Lying down			
Sitting			
Rising from Sitting			
Standing			
Walking			
Bending			
Coughing or Sneezing or Both			

l. What else increases your pain? _____

m. Below is a list of treatments you may have used to relieve pain. For each of these, check whether you have tried the treatment, then, but only if you have tried it, whether or not it helped.

TREATMENTS	**NEVER TRIED**	**TRIED**	**HELPED**	**DIDN'T HELP**
Heat				
Massage				
Whirlpool				

TREATMENTS	NEVER TRIED	TRIED	HELPED	DIDN'T HELP
Traction				
Prescribed Exercise				
TNS (or TCS or TENS, transcutaneous stimulation)				
Biofeedback				
Trigger Point Injections				
Nerve Blocks				
Acupuncture				
Chiropractic Treatments				
Behavior Modification				
Counseling				
Back School				
Pain Clinic				

n. What other things relieve your pain? _____

_____

_____

o. Do you drink alcoholic beverages? ☐ Yes ☐ No How much? _____ How often? _____

p. Does drinking alcoholic beverages relieve your pain? ☐ Yes ☐ No

q. Rate your pain by circling the ***one*** number that best describes it (a rating of 10 would indicate pain so severe as to prohibit all activity – the worst pain you have ever had).

NONE				MODERATE						VERY SEVERE
0	1	2	3	4	5	6	7	8	9	10

r. How much does the pain interfere with your activities? Circle the ***one*** number that describes the amount of interference (a rating of 10 would indicate that you must lie down all of the time and cannot do anything).

NONE				MODERATE						VERY SEVERE
0	1	2	3	4	5	6	7	8	9	10

s. What things did you do *in the past* but are not able to do *now* because of the pain? _____

_____

15. ***PHYSICAL LIMITATIONS: In the questions in section 15 you will be asked to actually do something to enable you to answer the questions. It is very important that you actually do them. If you do not understand what you are being asked to do, call my office so that Sherry or I can explain it to you.***

a. ***SITTING***:

Do you have any trouble sitting, including sitting for more than an hour without getting up? ☐ Yes ☐ No

Does it make a difference what kind of chair you sit on? ☐ Yes ☐ No

What kind of chair is best for you? _____

Do you need to elevate your legs while sitting? ☐ Yes ☐ No If yes, did your doctor tell you to? ☐ Yes ☐ No

Where in your body do you have pain or discomfort when you sit too long? _____

_____

1) Actually sit in a chair similar to one that might be provided at work (not a recliner, a soft chair or a couch) to see how long you can sit *continuously in one stretch* before you must get up and move around or lie down. You should go to the bathroom before you start. And you should time yourself with a watch or a clock. Write down the number of hours (even if 0) and minutes.

Hours _____ Minutes _____

2) What happened to make you get up from sitting (check all that apply)? ☐ Pain ☐ Numbness

☐ Stiffness ☐ Bathroom Other: _____

3) What do you do to relieve that pain or other discomfort before you can continue sitting?

☐ Stand up for a few minutes without walking away from the chair. How many minutes? _____

☐ Stand up and walk around away from the chair for a few minutes. How many minutes? _____

How far did you have to walk away from the chair? _____

☐ Lie down. How many minutes? _____

Other: _____

Check all activities you have trouble performing while sitting: ☐ Bending at the waist ☐ Reaching in front of you

☐ Reaching overhead ☐ Pulling to you ☐ Pushing away from you ☐ Handling (grasping) an item

☐ Feeling ☐ Fingering ☐ Other: _____

b. ***STANDING:***

Do you have any trouble standing, including standing for more than an hour without sitting, walking about or lying

down? ☐ Yes ☐ No

1) If yes, then actually stand as long as you can to see how long you can stand *continuously in one stretch* without sitting down or walking around. You should go to the bathroom before you start and time yourself with a watch or a clock. Write down the number of hours (even if 0) and minutes.

Hours _____ Minutes _____

2) What happens to make you stop standing? ☐ Pain ☐ Numbness ☐ Stiffness ☐ Lose balance

☐ Dizziness ☐ Other: _____

Where in your body do you have pain or discomfort when you stand too long? _____

_____

What do you do to relieve that pain or discomfort?

☐ Sit down for a few minutes. For how many minutes? _____

☐ Lie down for a few minutes. For how many minutes? _____

☐ Walk around for a few minutes away from where you were standing. For how many minutes? _____

☐ Other: _____

Check all activities you have trouble performing while standing: ☐ Lifting ☐ Balancing ☐ Reaching in front

☐ Reaching over head ☐ Grasping with hands ☐ Fingering ☐ Feeling ☐ Pulling to you

☐ Pushing away from you ☐ Bending at the waist ☐ Other: _____

_____

c. ***WALKING:***

Do you have any trouble walking, including standing for more than an hour without stopping and standing still or sitting down or lying down? ☐ Yes ☐ No

1) If yes, then actually walk as far as you can to determine how long you can walk *continuously in one stretch* without stopping You should time yourself with a watch or a clock. Write down the number of hours (even if 0) and minutes.

Hours _____ Minutes _____

2) What caused you to stop walking? ☐ Pain ☐ Shortness of breath

☐ Other discomfort (specify the discomfort): _____

Where in your body is the pain or discomfort?: _____

What do you do to relieve that pain or discomfort?

☐ Sit down for a few minutes. For how many minutes? _____

☐ Lie down for a few minutes. For how many minutes? _____

☐ Other: _____

Do you ever use a cane or other device to help you walk? ☐ Yes ☐ No If yes, what do you use? _____

If yes, do you always use it? ☐ Yes ☐ No If you use one, did your doctor prescribe it? ☐ Yes ☐ No

If your doctor did not prescribe the cane or other device, does your doctor know that you use it? ☐ Yes ☐ No

Check examples of activities you have trouble performing while walking: ☐ Carrying

☐ Balancing ☐ Pulling to you ☐ Pushing away from you ☐ Bending at the waist

☐ Other: _____

d. ***LIFTING AND CARRYING:***

Do you have any limitations lifting or carrying? ☐ Yes ☐ No

If yes, actually go to a grocery store (unless you have all these items at home) and actually try lifting (one at a time) a 5 pound bag of potatoes or sugar, a full gallon of milk or water, a 10 pound bag of potatoes, and a 20 pound bag of potatoes. Actually try with your right hand, then with your left hand, and then with both hands. Remember what happened or write it down so that you can answer the following questions.

Can you lift a full gallon of milk or water *with your right hand*? ☐ Yes ☐ No

With your *left* hand? ☐ Yes ☐ No With *both* hands? ☐ Yes ☐ No.

Can you carry it up to the checkout counter? ☐ Yes ☐ No.

Can you lift a 5 pound bag of potatoes or sugar *with your right hand*? ☐ Yes ☐ No

With your *left* hand? ☐ Yes ☐ No With *both* hands? ☐ Yes ☐ No.

Can you carry it up to the checkout counter? ☐ Yes ☐ No.

Can you lift a 10 pound bag of potatoes *with your right hand*? ☐ Yes ☐ No

With your *left* hand? ☐ Yes ☐ No With *both* hands? ☐ Yes ☐ No.

Can you carry it up to the checkout counter? ☐ Yes ☐ No.

Can you lift a 20 pound bag of potatoes *with your right hand*? ☐ Yes ☐ No

With your *left* hand? ☐ Yes ☐ No With *both* hands? ☐ Yes ☐ No

Can you carry it up to the checkout counter? ☐ Yes ☐ No.

What is the heaviest thing that you encounter in your everyday life, which you can actually lift or carry *frequently* (15 or more times) during the day?

_____ How much does it weigh? _____

What is the heaviest thing that you encounter in your everyday life, which you can actually lift or carry *occasionally* (less than 15 times, but more than 3 times) during the day?

_____ How much does it weigh? _____

What is the heaviest thing that you encounter in your everyday life, which you can actually lift or carry, but *rarely* (3 or fewer times), during the day?

_____ How much does it weigh? _____

What happens when you try to lift or carry too much? ☐ I drop it. ☐ I lose my balance.

☐ Other: _____

e. ***ARMS AND HANDS:***

Are you left or right handed? ☐ Left ☐ Right ☐ Both (ambidextrous)

Do you have any problems using your hands or arms? ☐ Yes ☐ No If yes, which hand? _____

Can you make a fist with each hand (you should actually try to)? ☐ Yes ☐ No

Can you touch each finger to the thumb on each hand (you should actually try to)? ☐ Yes ☐ No

Do your hands shake? ☐ Yes ☐ No

Do your hands or wrists hurt? ☐ Yes ☐ No

Do you have any trouble with your hands being numb or having pins and needles? ☐ Yes ☐ No

Do you have any trouble with dropping things? ☐ Yes ☐ No

If yes, how often do you drop something? ☐ Almost every day ☐ At least once a week

What is the last thing you remember dropping? _____

About when (what day) did you drop it? _____

Do you have a problem reaching above your head? ☐ Yes ☐ No

Reaching in front of you? ☐ Yes ☐ No

Reaching to either side? ☐ Yes ☐ No

Handling (seizing, holding, grasping, turning) something? ☐ Yes ☐ No

Fingering (picking, pinching)? ☐ Yes ☐ No

Feeling the size, shape, temperature, or texture of something with your fingers? ☐ Yes ☐ No

f. ***LEGS AND FEET:***

Do you have any trouble using your legs or feet? ☐ Yes ☐ No If yes, which leg? _____

Do you have any trouble using your legs and feet to drive a car? ☐ Yes ☐ No If yes, which leg? _____

Can you push with your legs and feet? ☐ Yes ☐ No If no, which leg? _____

Do your legs or feet hurt? ☐ Yes ☐ No If yes, which ones? _____

For how long do they hurt? ☐ Constantly If not constantly, how much during the day? _____

Are they sometimes numb? ☐ Yes ☐ No If yes, which ones? _____

For how long are they numb? ☐ Constantly If not constantly, how much during the day? _____

Do your legs get stiff? ☐ Yes ☐ No If yes, which ones? _____

For how long do they hurt? ☐ Constantly If not constantly, how much during the day? _____

Does something cause your legs or feet to hurt or be numb or be stiff? ☐ Yes ☐ No

If yes, what? _____

Do you only have trouble with using your legs or feet when you have to use them repetitively?

☐ Yes ☐ No

Describe any other trouble you have using your legs or feet. _____

_____

g. ***POSTURAL LIMITATIONS:***

Do you have any trouble with any of the following postures? Check boxes to indicate that you have no trouble with the posture or that you can't be in the posture at all or that you can be in it for a maximum of 3 or 4 times a day or for a maximum of 3 or 4 times an hour. There should only be one check after each posture.

Stooping:[1] ☐ No trouble ☐ Not at all ☐ No more than 3 or 4 times a day ☐ No more than 3 or 4 times an hour

Squatting: ☐ No trouble ☐ Not at all ☐ No more than 3 or 4 times a day ☐ No more than 3 or 4 times an hour

Kneeling ☐ No trouble ☐ Not at all ☐ No more than 3 or 4 times a day ☐ No more than 3 or 4 times an hour

Crouching: ☐ No trouble ☐ Not at all ☐ No more than 3 or 4 times a day ☐ No more than 3 or 4 times an hour

Crawling: ☐ No trouble ☐ Not at all ☐ No more than 3 or 4 times a day ☐ No more than 3 or 4 times an hour

h. ***CLIMBING LIMITATIONS:***

Climbing stairs: ☐ No trouble ☐ Not at all ☐ Some If some, how many steps? _____

Climbing ladders: ☐ No trouble ☐ Not at all ☐ Some If some, how many steps? _____

Climbing ropes: ☐ No trouble ☐ Not at all ☐ Some If some, how high can you climb? _____

Climbing scaffolds: ☐ No trouble ☐ Not at all ☐ Some If some, explain what you can do: _____

i. ***ENVIRONMENTAL RESTRICTIONS:*** Are there any limitations on your activities, or problems which you encounter, having to do with any of the following situations? Please describe the problem.

☐ Being at unprotected heights (no guard rail, for example): _____

☐ Being around moving machinery: _____

☐ Being exposed to marked changes in temperature or humidity: _____

☐ Being exposed to dust, fumes or gases: _____

[1] Stooping is bending at the waist. If you can bend, can you bend and touch your toes? ☐ Yes ☐ No
If no, can you touch your knees? ☐ Yes ☐ No

MEDICATIONS:

17. For each ***prescription drug*** you are *presently* taking, please complete the following (use extra paper if necessary):

NAME OF MEDICATION	DOSAGE AND TIMES PER DAY OR OTHER PERIOD	FOR WHICH CONDITION	PRESCRIBING DOCTOR	APPROXIMATE DATE STARTED (EXACT DATE IF KNOWN)	SIDE EFFECTS FROM THIS DRUG

18. For each ***non-prescription drug*** you are taking, complete the following (use extra paper if necessary):

NAME OF MEDICATION	HOW MANY TIMES A DAY?	HOW MUCH EACH TIME?	FOR WHICH CONDITION

HOSPITALIZATIONS (INPATIENT):

19. For each *hospitalization* (**where you stayed at least one night**), please complete the following chart (use extra paper if necessary):

List your most recent hospitalization first and work your way back to about five years before you became unable to work.

NAME AND ADDRESS OF HOSPITAL	APPROXIMATE DATES	WHY WERE YOU HOSPITALIZED	DESCRIBE THE TREATMENT YOU RECEIVED	NAMES OF DOCTORS WHO TREATED YOU

HOSPITALIZATIONS, CLINIC OR CENTER VISITS (OUTPATIENT):

20. For each ***outpatient*** *visit to a hospital, diagnostic center, rehabilitation center or physical therapy clinic*, (for example, for emergency room care, physical therapy or other treatment, diagnostic tests, etc.) please complete the following chart (use extra paper if necessary):

List your most recent visit first and work your way back to about 5 years before you became unable to work.

NAME AND ADDRESS OF HOSPITAL, CENTER OR CLINIC	APPROXIMATE. DATE	DESCRIBE TREATMENT OR DIAGNOSTIC TESTS	DOCTORS OR THERAPISTS

DOCTORS, CHIROPRACTORS, THERAPISTS, ETC.:

21. For each doctor, chiropractor, psychologist, psychological counselor, etc. you have seen, please complete the following chart (use extra paper if necessary):
List the doctors you are seeing now first and work your way back to about five years before you became unable to work.

NAME AND ADDRESS OF DOCTOR, CHIROPRACTORS, THERAPISTS, ETC.	DATE OF FIRST VISIT (APPROX.)	DATE OF LAST VISIT (APPROX.)	HOW MANY VISITS TOTAL?	WHICH CONDITION WAS TREATED?	DESCRIBE ANY RESTRICTION OF ACTIVITIES IMPOSED OR WHAT YOU WERE TOLD ABOUT YOUR CONDITION

22. For each doctor the ***Social Security Administration*** sent you to for examination concerning your disability, please complete the following

NAME AND ADDRESS OF DOCTOR	DOCTOR'S SPECIALTY	DATE OF EXAM.	LENGTH OF EXAM (MINUTES)	DESCRIBE THE EXAMINATION AND ANYTHING THE DOCTOR TOLD YOU ABOUT YOUR CONDITION

23. What is the name, address and telephone number of **someone who doesn't live with you**, but will always be able to find you?

    Name: _____

    Address: _____

    _____

    Telephone numbers: _____

    Relationship to you: _____

24. Are the medical providers listed on your denial letters a complete listing of those needed to get a complete understanding of your disability? ☐ Yes ☐ No

    If no, what other medical providers should be contacted? _____

    _____

    _____

25. Other information you consider important: _____

    _____

26. Did you need help to complete this questionnaire? ☐ Yes ☐ No If yes, who helped you? _____

    _____

    _____

27. <u>It is important that you date and sign this questionnaire</u>.

    Date: _____ _____

    CLIENT FULL NAME