QME RE-EVALUATION INTAKE FORM

APPLICANT LAST NAME: _____ APPLICANT FIRST NAME: _____

DATE OF EVALUATION: _____ DATE OF BIRTH: _____ Sex: Male Female

Dominant Hand: LEFT RIGHT BOTH Ethnicity/Race: _____

_____

Below information to be completed by Dr. Bradley Chesler, QME

Vitals: T: _____ BP: _____/_____ P: _____ R: _____ HT: _____ WT: _____ Pulse Ox: _____

INTERIM HISTORY

Please answer the following questions regarding your condition **since the time of your last evaluation with this doctor.**

1. Since your last evaluation, are you: (**Check one**) [ ] BETTER [ ] SAME [ ]WORSE

2. What treatment have you had since your last evaluation? (**Check all that apply**)

[ ] Physical Therapy _____ body part /# of sessions
[ ] Acupuncture _____ # of sessions
[ ] Chiropractic _____# of sessions
[ ] Injections _____/_____ (body part/date) _____/_____ (body part/date)
[ ] Medications _____ name of medication
[ ] Surgery _____ body part/date
[ ] Other _____
[ ] None

3. What percent improvement did you feel following the above treatment? _____**%**
4. Did you decline any recommended treatment? (**Circle one**) Yes No
   If yes, explain: _____
5. Did your insurance deny any recommended treatment? **(Circle one**) Yes No
   If yes, explain: _____
6. Are there any new complaints since your last evaluation? (**Circle one**) Yes No

Body Region	Date Symptoms Started	What was the cause?
_____	_____(mm/yyyy)	_____
_____	_____(mm/yyyy)	_____
_____	_____(mm/yyyy)	_____

7. Have you sustained a new injury since the last evaluation? (**Circle one**): Yes No

If yes, date: _____ Were there any witnesses? Yes No

If yes, Name of witnesses _____

Explain what happened:

_____

_____

_____

WORK STATUS SINCE LAST EVALUATION [ ] check here if no change since your initial evaluation

Please answer the following questions regarding your work status since your last evaluation:

8. Are you currently working with the same employer? (**Circle one**): Yes No
   If YES, are there any restrictions?
   _____
   _____
   If No, please complete all fields below:

JOB TITLE: _____ EMPLOYER: _____

Date you started this employment: _____ (mm/dd/yyyy)

How many hours do you work per day? _____
How many days do you work per week? _____

Job description:

a. What tasks do you do? (i.e., Folding laundry, sweeping floor, unloading truck)
   _____
b. What tools or machines do you operate? (i.e., Forklift, pallet-jack)
   _____

c. Are you exposed to: [ ] Chemicals [ ] Noise [ ] Fumes [ ]Smoke [ ] Mold [ ] Dust
   (**Check all that apply**)

d. During your work shift, you were: **(check ONE)**
   [ ] MOSTLY SITTING [ ] MOSTLY ON YOUR FEET (Standing/walking)
   [ ] EQUAL PARTS SITTING AND ON YOUR FEET

e. What is the **maximum** weight you are required to lift by yourself? _____lbs.

f. What is the **typical** weight you are required to lift by yourself? _____lbs.

g. Which of the following did you perform **REPETITIVELY** or **CONSTANTLY? (CHECKBOXES)**
   [ ] TILTING HEAD UP/DOWN [ ] BENDING TO THE FLOOR
   [ ] KNEELING/SQUATTING [ ] STAIRS/LADDERS
   [ ] WRITING/TYPING [ ] FORCEFUL GRIPPING/GRASPING
   [ ] REACHING OVERHEAD [ ] ASSEMBLY WORK USING HANDS/ARMS
   [ ] Other:
   _____

CURRENT CONDITIONS/COMPLAINTS

Please complete the greatest area of complaint by answering the following questions regarding your **current** condition (within the last 30 days)

9. Do you have any pain? (**Circle one**) Yes No (if No, Skip to Occupational History)

   Where is it? _____ specify R or L if applicable

10. Rate the intensity of your pain today (**circle one**)

0	1	2	3	4	5	6	7	8	9	10
No pain		**mild**			**Moderate**		**Severe**			**Debilitating**

11. What does the pain feel like? **(Circle all that apply)**

Dull **Sharp** **Burning** **Throbbing** **Pins & Needles** **Numbness & Tingling** **No Pain**

Other, explain: _____

12. Did any of these symptoms exist prior to your injury/illness? Yes No
Explain: _____

13. Does your present pain travel? Yes No

If Yes, Where? _____

14. How often does it happen? _____

15. How often to you feel the pain? **(Circle one)** **Rare** **Occasional** **Intermittent** **Constant**

16. Activity or position that makes the pain worse _____
_____

17. Activity or position that makes the pain better _____
_____

18. Is there any stiffness? Yes No Where is it? _____
19. Is there any weakness? Yes No Where is it? _____
20. Is there any swelling? Yes No Where is it? _____
21. Is there any grinding? Yes No Where is it? _____
22. Is there any locking? Yes No Where is it? _____
23. Is there any giving way? Yes No Where is it? _____
24. Any difficulty with bowel, bladder or sexual functions? Yes No
25. Do you have any deformity/scar? Yes No _____

OCCUPATIONAL HISTORY

[ ] check here if no change since your initial evaluation

JOB TITLE #1: _____ EMPLOYER: _____

Dates of employment: _____ to _____ (mm/dd/yyyy)

How many hours did you work per day? _____
How many days did you work per week? _____

Job description: What tasks did you do? (i.e., Folding laundry, sweeping floor, unloading truck)
_____
What tools or machines did you operate? (i.e., Forklift, pallet-jack)
_____

Were you exposed to: [ ] Chemicals [ ] Noise [ ] Fumes [ ]Smoke [ ] Mold [ ] Dust (**Check all that apply**)

JOB TITLE #2: _____ EMPLOYER: _____

Dates of employment: _____ to _____ (mm/dd/yyyy)

How many hours did you work per day? _____
How many days did you work per week? _____

Job description: What tasks did you do? (i.e., Folding laundry, sweeping floor, unloading truck)
_____
What tools or machines did you operate? (i.e., Forklift, pallet jack)
_____

Were you exposed to: [ ] Chemicals [ ] Noise [ ] Fumes [ ]Smoke [ ] Mold [ ] Dust (**Check all that apply**)

HISTORY OF PREVIOUS INDUSTRIAL INJURIES **[ ] Check if none**

26. Have you ever had any other workers' compensation injuries? Yes No
    If Yes, please complete questions #86 to #102.
27. Name of Employer: _____
28. Occupation: _____
29. Job Duties/Tasks: _____
30. What part (s) of the body was/were injured? _____
    _____
31. _____
32. Did you report the injury? Yes No **(Circle one)**
33. What was the date (s) and time of injury? (mm/dd/yyyy)_____ Time: _____
34. How did the injury/accident happen? _____
    _____
    _____
    _____
35. Were you offered medical treatment? Yes No **(Circle one)**
    If yes, Name of physician: _____
36. What treatment was ordered/prescribed for this injury? (**Check all that apply**)

[ ] Physical Therapy _____ body part /# of sessions
[ ] Acupuncture _____ # of sessions
[ ] Chiropractic _____# of sessions
[ ] Injections _____/_____ (body part/date) _____/_____ (body part/date)
[ ] Medications _____ name of medication
[ ] Surgery _____ body part/date
[ ] Other _____
[ ] None

37. Name of other physicians seen for this injury: _____
38. What % of improvement did you feel with the above treatment? _____ %
39. Were you placed on modified duty? Yes No **(Circle one)**

If yes, what were your restrictions and how long on restriction?

_____
_____
_____

40. Did you fully recover from this injury? Yes No **(Circle one)**

41. Is this claim still open? Yes No **(Circle one)**

42. Was there an award or permanent disability from this injury? Yes No **(Circle one)**
    If Yes, Did the award include Future Medical Care? Yes No **(Circle one)**

43. Do you have formal work restrictions, or did you self-impose any work restrictions following this injury?
    Yes No If yes, describe _____
    _____
    _____

HISTORY OF PREVIOUS NON-INDUSTRIAL INJURIES [ ] check here if no change since your initial evaluation

Please answer the following questions regarding prior non-work-related injuries (including car accidents, sports injuries, and any other injuries sustained outside of a work environment.

Body part(s) injured: _____ Date of Injury: _____ (mm/dd/yyyy)
How did this injury occur? _____
What treatment did you receive? _____
Did you file a lawsuit as a result of this injury? (**Circle one**) Yes No
If yes, please describe _____
Did you have work restrictions, or did you limit your work activities in any way following this injury?
(**Circle one**) Yes No
If yes, please describe _____
If yes, do you still have these restrictions in place? (**Circle one**) Yes No

Body part(s) injured: _____ Date of Injury: _____ (mm/dd/yyyy)
How did this injury occur? _____
What treatment did you receive? _____
Did you file a lawsuit as a result of this injury? (**Circle one**) Yes No
If yes, please describe _____
Did you have work restrictions, or did you limit your work activities in any way following this injury?
(**Circle one**) Yes No
If yes, please describe _____
If yes, do you still have these restrictions in place? (**Circle one**) Yes No

Body part(s) injured: _____ Date of Injury: _____ (mm/dd/yyyy)
How did this injury occur? _____
What treatment did you receive? _____
Did you file a lawsuit as a result of this injury? (**Circle one**) Yes No
If yes, please describe _____
Did you have work restrictions, or did you limit your work activities in any way following this injury?
(**Circle one**) Yes No
If yes, please describe _____

If yes, do you still have these restrictions in place? (**Circle one**) Yes No

ACTIVITIES OF DAILY LIVING (ADLs)

Please review the listed ADLs. For each, place an "X" in the box which best describes your usual ability to perform the activity **over the past month**.

	OVER THE PAST MONTH			
ACTIVITY	No Difficulty	With Some Difficulty	With Moderate Difficulty	Unable
Self-Care/Personal Hygiene - Can You:				
Take a bath/shower normally?				
Brush your teeth?				
Comb/Brush your hair?				
Eat & Drink?				
Get dressed without help?				
Urinate?				
Have a bowel movement?				
Communication - Can You:				
Write?				
Type on a keyboard?				
See clearly?				
Hear clearly?				
Speak clearly?				
Physical Activity - Can You:				
Stand?				
Walk?				
Sit?				
Recline/Lie down?				
Climb stairs?				
Sensory Function - Can You:				
Hear?				
See?				
Feel what you touch?				
Smell?				
Taste what you eat?				
Hand Function - Can You:				
Grasp something?				
Hold something?				
Lift a gallon of milk?				
Lift a child?				
Travel - Can You:				
Ride in a car?				
Drive a car?				
Fly in an airplane?				
Sexual Function - Can You				
Have sexual intercourse?				
Achieve orgasm?				

Sleep - Can You:				
Fall asleep?				
Maintain sleep?				

FAMILY HISTORY **[ ] check here if no change since your initial evaluation**

Does anyone in your ***family*** have a history of any of the following conditions? (list relatives in space provided)

Cancer	Y	N	_____
Heart Disease	Y	N	_____
High Cholesterol	Y	N	_____
Diabetes	Y	N	_____
Lung Disease	Y	N	_____
High Blood Pressure	Y	N	_____
Bleeding or Blood Clotting Disorder	Y	N	_____
Reaction to Anesthesia	Y	N	_____

SOCIAL HISTORY **[ ] check here if no change since your initial evaluation**

MARITAL STATUS: (**check one**) [ ]MARRIED [ ]SINGLE [ ]SEPARATED [ ]DIVORCED [ ]WIDOWED

Alcohol Use:	Y	N	Frequency: _____
Tobacco Use:	Y	N	Frequency: _____
Recreational Drug Use:	Y	N	Type: _____ Frequency _____
Sports & Hobbies:	Y	N	_____

PAST MEDICAL HISTORY **[ ] check here if no change since your initial evaluation**

Do you have a history of any of the following conditions?

High Blood Pressure	Y	N
Diabetes	Y	N
Cardiac (heart) Issues	Y	N
Pulmonary (lungs) Issues	Y	N
Renal (kidney) Issues	Y	N
Gastrointestinal Issues	Y	N

ANY PREVIOUS HOSPITALIZATIONS: **[ ] check here if no change since your initial evaluation**

NAME OF HOSPITAL *REASON* *DATE*

_____

_____

SURGICAL HISTORY: **[ ] check here if no change since your initial evaluation**

OPERATION *SURGEON & CITY* *DATE*

_____

_____

MEDICATION ALLERGIES: YES NO **[ ] check here if no change since your initial evaluation**

NAME OF MEDICATION *REACTION*

_____

_____

MEDICATIONS CURRENTLY TAKING: **[ ] check here if no change since your initial evaluation**

NAME OF MEDICATION *DOSAGE & FREQUENCY*

_____
_____
_____
_____

REVIEW OF SYSTEMS **[ ] check here if no change since your initial evaluation**

Circle any specific item in each section that applies to you and explain any Yes answers in the space at the bottom of the page.

GENERAL	Fevers, chills, fatigue, unexpected weight loss, or weight gain?	Yes	No
EYES	Corrective lenses, blurry vision, redness, watering of the eyes, or eye pain?	Yes	No
EARS, NOSE, THROAT (ENT)	Headaches, difficulty swallowing, nose bleeds, ringing in the ears, or earaches?	Yes	No
CARDIOVASCULAR	Chest pain, palpitations, fainting or murmurs?	Yes	No
RESPIRATORY	Shortness of breath, wheezing, coughing, tightness, inspiration pain, or snoring?	Yes	No
GASTROINTESTINAL	Heartburn, stomach irritation, nausea, vomiting, constipation, diarrhea, and bloody/tarry stools?	Yes	No
GENITOURINARY	Frequency and urgency, difficult/painful urination, flank pain, or bleeding?	Yes	No
MUSCULOSKELETAL	Joint pain, muscle pain, stiffness, instability, swelling, redness, and heat?	Yes	No
SKIN	Skin changes, poor healing, rash, itching, and redness?	Yes	No
NEUROLOGIC	Numbness/tingling, unsteady gait, dizziness, tremors, or seizures?	Yes	No
PSYCHIATRIC	Anxiety, depression, or suicidal ideations?	Yes	No
HEMATOLOGIC/ LYMPHATIC	Easy bleeding or bruising?	Yes	No
ENDOCRINE	Excessive thirst or urination or heat/cold intolerance?	Yes	No

PLEASE WRITE THE SYSTEM OF ANY "YES" ANSWERS ABOVE AND EXPLAIN EACH ONE OF THEM HERE.