|  |  |
| --- | --- |
|  | **Monarch Rehabilitation & Sports Wellness Center** Our mission is to provide excellence in rehabilitation services to enhance overall physical health, fitness, and quality of life by providing educational classes, work hardening / conditioning programs, and individualized treatment programs.facebook.com/MonarchRehab e-mail: monarch.rehab@gmail.com |

|  |  |
| --- | --- |
| **EXAMINEE TIME IN:** | **EXAMINEE NAME:** |
| **SS#:** | **DATE OF BIRTH:** | **AGE:** |
| **SEX: □** Male **□** Female | **HEIGHT:** | **WEIGHT:** |
| **HANDEDNESS: □** Left **□** Right **□** Both |  |
|  |
| **PRIOR VISITS TO THIS OFFICE OR WITH THIS DOCTOR BEFORE: □** Yes **□** No |
| **IF YES, DATE:** | **IF YES, DOCTOR YOU SAW:** |
|  |
| **ARRIVAL TO TODAY’S APPOINTMENT: Indicate how you got to the appointment today** |
| **□** Drove Self **□** Brought by friend/family **□** Bus **□** Cab/Uber/Lyft **□** Medical Transport **□** Other: |
|  |
| **EMERGENCY CONTACT NAME:** |
| **RELATIONSHIP:** | **PHONE:** |

**PAST MEDICAL HISTORY**

|  |
| --- |
| **CHECK AND CIRCLE ALL PAST MEDICAL HISTORY THAT APPLIES:** |
| **□ NONE** – My past medical history is negative/non remarkable |
|  |
| **□** High Blood Pressure or Low Blood Pressure (circle) | **□** History of Mental Illness (before this injury/illness) |
| **□** Heart Disease | **□** History of Depression (before this injury/illness) |
| **□** Diabetes: **□** Type I **□** Type II | **□** Gallstones |
| **□** Lung Disease | **□** Kidney Stones |
| **□** Cancer: Type: | **□** Hepatitis: Type: |
| **□** Asthma | **□** Anemia |
| **□** HIV | **□** Bladder Problems |
| **□** Bowel Problems | **□** Anxiety/Nervousness |
| **□** Dizziness/Fainting | **□** Forgetfulness |
| **□** Loss of Sleep | **□** Dramatic Weight Changes: Loss Gain |
| **□** Fatigue | **□** Chest Pain |
| **□** Irregular Heartbeat/Palpitations/Rapid Heartbeat | **□** Swelling of Ankles |
| **□** Stroke/Heart Attack | **□** Asthma |
| **□** COPD | **□** Blood in urine |
| **□** Painful Urination | **□** Frequent Urination |
| **□** Lack of Bladder Control | **□** Headaches |
| **□** Blurred Vision/Double Vision/Floaters | **□** Blind: Partially Completely Right Left |

|  |  |
| --- | --- |
| **□** Earache/Ear Discharge/Ringing in ears | **□** Nosebleeds |
| **□** Difficulty Swallowing | **□** Difficulty Speaking |
| **□** Decreased Appetite | **□** Excessive Hunger |
| **□** Excessive Thirst | **□** Stomach Pain |
| **□** Indigestion/Gas/Bloating | **□** Bowel Changes/Loss of Bowel Control |
| **□** Diarrhea | **□** Constipation |
| **□** Rectal Bleeding | **□** Nausea/Vomiting |
| **□** Vomiting Blood | **□** Allergies: |
| **□** Other |  |
| **□** Other |  |
|  |
| Martial Status: | **□** Married **□** Single **□** Widowed **□** Divorced |
| Tobacco Use: | **□** None **□** Occasionally **□** Frequently **□** Every Day |
| Alcohol Consumption: | **□** None **□** 1-3 per week **□** 4-7 per week **□**+7 per wk |
| Do you consume caffeine | **□** None **□** 1-3 per week **□** 4-7 per week **□**+7 per wk |
| Do you exercise regularly: | **□** Yes **□** No |
| Did you exercise prior to your work related injury: (if applicable) | **□** Yes **□** No |
| **FEMALES ONLY:** Are you currently pregnant? | **□** Yes **□** No | How far along: |
|  |
| **PREVIOUS WORK RELATED INJURY/ILLNESS:** |
| Have you ever been hurt at work **prior** to this injury/illness? | **□** Yes **□** No If yes, please list below |
| Body Area/Injury: | Date: |
| Body Area/Injury: | Date: |
| Body Area/Injury: | Date |
|  |
| **PREVIOUS NON WORK RELATED INJURY/ILLNESS TO THE SAME/CURRENT INJURED AREA(S):** |
| Do you have a history of an injury or problem to the samebody area(s) before this work related injury happened? | **□** Yes **□** No |
|  |
| When did this occur? |
| Please explain: |
|  |
| **SURGICAL HISTORY – NOT DONE AS PART OF THIS INJURY/ILLNESS:** |
| **□ NONE –** I have never had any surgery that wasn’t related to this injury/illness |
|  |
| SURGERY: | DATE: |
| SURGERY: | DATE: |
| SURGERY: | DATE: |
| SURGERY: | DATE |

**CURRENT INJURY DETAILS/SPECIFICS**

|  |
| --- |
| **DESCRIPTION OF INJURY/ILLNESS: Tell us exactly how your injury/accident/illness happened** |
|  |
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|  |
| **BODY AREA(S) INJURED FOR THIS WORK RELATED CLAIM ONLY:**LIST ALL BODY AREAS/INJURIES/ILLNESSES THAT YOU FEEL HAPPENED BECAUSE OF THE INJURY THAT HAPPENED AT WORK AND ALL AREAS THAT YOU FEEL SHOULD BE INCLUDED |
| **□** Low Back (Lumbar Spine) | **□** Shoulder: | Left | Right | Both | **□** Hip: | Left | Right | Both |
| **□** Mid Back (Thoracic Spine) | **□** Elbow: | Left | Right | Both | **□** Knee: | Left | Right | Both |
| **□** Neck (Cervical Spine) | **□** Wrist: | Left | Right | Both | **□** Ankle: | Left | Right | Both |
| **□** Pelvis | **□** Hand: | Left | Right | Both | **□** Foot: | Left | Right | Both |
| **□** Ribs | **□** Finger: Left Which Finger(s): | Right | Both | **□** Toe: Left Which Toe(s): | Right | Both |
| **□** Head | **□** Eye: | Left | Right | Both | **□** Dental: |
| **□** Face | **□** Traumatic Brain Injury | **□** Post Traumatic Stress Disorder |
| Other: |

|  |  |
| --- | --- |
| **LIFTING: Was your injury caused by lifting something?** | **□** Yes **□** No |
| What was lifted? |  |
| How much did the item(s) weigh? |  |
| How often do you perform this lifting task each work day?**□** Only this one time **□** Almost Never **□** Occasionally (Less than 3 hours) **□** Frequently (3-6 hours) **□** Constantly (6+) |
|  |
| **FALL: Was your injury due to a fall?** | **□** Yes **□** No |
| Did you lose consciousness when you fell? | **□** Yes **□** No |
| How did your fall occur? |
| Direction of your fall/How did you land?**□** Forward **□** Backward **□** Left Side **□** Right Side |
|  |
| **MVA: Were you involved in a motor vehicle accident?** | **□** Yes **□** No |
| Were you the driver or passenger when accident happened? | **□** Driver **□** Passenger |
| Where were you riding in the vehicle if not driving? |  |
| Type of vehicle you were driving/riding in? |  |
| Was there another vehicle involved in the accident? | **□** Yes **□** No |
| If yes, what type of vehicle was involved? |  |
| If yes, was the driver or passengers in other vehicle hurt? | **□** Yes **□** No **□** Unknown |

|  |
| --- |
|  |
| **REPETITIVE ACTION: Was your injury caused by repetitive action?** | **□** Yes **□** No |
| What kind of repetitive action were you doing? |
| How often do you perform this task each work day?**□** Only this one time **□** Almost Never **□** Occasionally (Less than 3 hours) **□** Frequently (3-6 hours) **□** Constantly (6+) |
| How long were you performing this job before you had problem/pain? |  |
| How many hours per day do you perform this activity? |  |
| How many days per week do you perform this activity |  |

**DIAGNOSTIC TESTING/STUDIES/CONSULTS**

|  |
| --- |
| **WHAT DIAGNOSTIC TESTS HAVE YOU HAD FOR THIS INJURY/ILLNESS? JUST THIS INJURY ONLY** |
| **□ X-Rays:** What body area(s): |
| **□ MRI:** What body area(s): |
| **□ EMG/NCV:** What body area(s): |
| **□ CT Scan:** What body area(s): |
| **□ Myelogram**: What body area(s): |
| **□ Functional Capacity Evaluation:** Date Last Performed: |
| **□ Psychological/Neuropsychological Evaluation/Testing:** Date Last Performed: |
| **□ Other:** |
| **□ Other:** |
| **□ Other:** |
| **□ PRIOR IMPAIRMENT RATING DETERMINATION BY ANOTHER DOCTOR** | **□** Yes **□** No **□** Don’t Know |

**TREATMENT HISTORY**

|  |
| --- |
| **TREATMENT(S): Please list all treatments you have had for JUST THIS INJURY ONLY** |
| **□** Physical Therapy | How Long: | Did it help? **□** Yes **□** No |
| **□** Chiropractic Treatment/Care | How Long: | Did it help? **□** Yes **□** No |
| **□** Work Hardening | How Long: | Did it help? **□** Yes **□** No |
| **□** Occupational Therapy | How Long: | Did it help? **□** Yes **□** No |
| **□** Massage Therapy | How Long: | Did it help? **□** Yes **□** No |
| **□** Therapeutic Ultrasound | How Long: | Did it help? **□** Yes **□** No |
| **□** Tens Unit | How Long: | Did it help? **□** Yes **□** No |
| **□** Injections | How Many: | Did it help? **□** Yes **□** No |
| **□** Other: | How Long: | Did it help? **□** Yes **□** No |
|  |
| **MEDICATIONS: Please list ALL prescription medications and over the counter drugs currently taking** |
| Medication Name or What Used For | How Much & How Often do you take? | Last time you took it? |
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**SURGICAL HISTORY – FOR THIS INJURY/ILLNESS**

|  |  |
| --- | --- |
| **SURGERY/PROCEDURE YOU HAD** | **DATE OF PROCEDURE** |
|  |  |
|  |  |
|  |  |
|  |  |
| **DID YOU HAVE PHYSICAL THERAPY AFTER SURGERY?** | **□** Yes **□** No |  |

**PENDING TREATMENTS/SURGERY – FOR THIS INJURY/ILLNESS**

|  |
| --- |
| **CHECK OFF ANY ADDITIONAL TREATMENT(S) THAT HAVE BEEN ORDERED/RECOMMENDED FOR YOU THAT YOU HAVE NOT HAD DONE YET:** |
|  |
| **□** I don’t have any additional treatment or surgery pending at this time |
|  |
| **□** Physical Therapy | **□** I want to do it | **□** I do not want to do it | **□** Denied by carrier/adjuster |
| **□** Chiropractic Treatment | **□** I want to do it | **□** I do not want to do it | **□** Denied by carrier/adjuster |
| **□** Work Hardening | **□** I want to do it | **□** I do not want to do it | **□** Denied by carrier/adjuster |
| **□** Occupational Therapy | **□** I want to do it | **□** I do not want to do it | **□** Denied by carrier/adjuster |
|  |  |
| **□** Injections | Type: | Body Area: | How Many: |
|  | **□** I want to do it | **□** I do not want to do it | **□** Denied by carrier/adjuster |
|  |
| * Other (Please describe any other treatments that you and your treating doctor have discussed you having)
* I want to do it **□** I do not want to do it **□** Denied by carrier/adjuster
 |
|  |
| **PENDING SURGERY FOR THIS INJURY THAT YOU HAVE NOT HAD DONE YET:** |
| Is surgery currently scheduled? | **□** Yes **□** No | If yes: | Date Scheduled: |
| What surgical procedure(s) have been recommended? |
| Do you want to have the surgery? | **□** Yes **□** No |  |
|  |

**WORK HISTORY**

|  |
| --- |
| **YOUR JOB/POSITION AT THE TIME OF YOUR INJURY/ILLNESS:** |
| What was your job title or position at the time of your injury/illness? |  |
| **PLEASE CHECK OFF ACTIVITIES YOU DID AS PART OF YOUR JOB ON A TYPICAL DAY BEFORE YOUR****INJURY/ILLNESS. Include how many hours per day each activity was performed and maximum weight Yu must be able to lift/carry by yourself** (Please note you cannot perform more than 2 activities for more than7 hours) Lifting/carrying activities are unassisted (without the use of dolly, pallet jack or assistance) |
|  |
| Standing | **□** None **□** Up to 3 hours **□** 3-6 hours **□** More than 7 hours | Item/Weight: |
| Walking | **□** None **□** Up to 3 hours **□** 3-6 hours **□** More than 7 hours | Item/Weight: |
| Sitting | **□** None **□** Up to 3 hours **□** 3-6 hours **□** More than 7 hours | Item/Weight: |

|  |  |  |
| --- | --- | --- |
| Reaching | **□** None **□** Up to 3 hours **□** 3-6 hours **□** More than 7 hours | Item/Weight: |
| Squatting | **□** None **□** Up to 3 hours **□** 3-6 hours **□** More than 7 hours | Item/Weight: |
| Kneeling | **□** None **□** Up to 3 hours **□** 3-6 hours **□** More than 7 hours | Item/Weight: |
| Stooping | **□** None **□** Up to 3 hours **□** 3-6 hours **□** More than 7 hours | Item/Weight: |
| Bending Over | **□** None **□** Up to 3 hours **□** 3-6 hours **□** More than 7 hours | Item/Weight: |
| Crawling | **□** None **□** Up to 3 hours **□** 3-6 hours **□** More than 7 hours | Item/Weight: |
| Climbing | **□** None **□** Up to 3 hours **□** 3-6 hours **□** More than 7 hours | Item/Weight: |
| Driving | **□** None **□** Up to 3 hours **□** 3-6 hours **□** More than 7 hours | Item/Weight: |
| Lifting | **□** None **□** Up to 3 hours **□** 3-6 hours **□** More than 7 hours | Item/Weight: |
| Carrying | **□** None **□** Up to 3 hours **□** 3-6 hours **□** More than 7 hours | Item/Weight: |
| Pushing | **□** None **□** Up to 3 hours **□** 3-6 hours **□** More than 7 hours | Item/Weight: |
| Pulling | **□** None **□** Up to 3 hours **□** 3-6 hours **□** More than 7 hours | Item/Weight: |
| Other: Please give a brief description of your daily job duties before your injury: |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
| Were you required to do any heavy lifting as part of your job before you got injured? | **□** Yes **□** No |
| What were you required to lift? |  |
| How much did this weigh in pounds? |  |
| How many times a day did you have to lift this? |  |
| Did you have any person(s) or machines helping you with the lifting? | **□** Yes **□** No |
| If yes, please explain: |
|  |
| **CURRENT WORK STATUS:** |
| Are you currently working? | **□** Yes **□** No |
| Are you currently working full time or part time? | **□** Full Time (35+hrs week) **□** Part Time |
| If you **ARE** currently working is it with or without restrictions? | **□** Without Restrictions **□** With Restrictions |
| Are you currently working with the same employer? | **□** Yes **□** No |
| Are you currently working in the same position? | **□** Yes **□** No |
| If your current job/position is not the same – List current job/position: |  |
| Are you earning the same pre-injury wage/salary? | **□** Same wages **□** Less wages **□** More wages |
|  |
| **IF YOU ARE WORKING NOW:** |
| Are you having any difficulties doing your job? | **□** Yes **□** No |
| What difficulties are you having? |
|  |
|  |
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| --- |
| **IF YOU ARE NOT WORKING NOW:** |
| Do you want to return to work at this time? | **□** Yes **□** No |
| Have you been released to work WITHOUT restrictions? | **□** Yes **□** No |
| Have you been released to work WITH restrictions? | **□** Yes **□** No |
| Has employer offered you a job that accommodates this restriction? | **□** Yes **□** No |
| If yes, and you have not returned to work – why not? |
|  |
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|  |

**CURRENT ACTIVITY LEVEL**

|  |
| --- |
| **IN AN EIGHT (8) HOUR DAY, WHAT PORTION OF THE DAY CAN YOU DO THE FOLLOWING ACTIVITES?****Does NOT have to be constantly** |
|  |
| Standing | **□** None **□** 2 hours **□** 4 hours **□** 6 hours **□** 9 hours | Other: |
| Walking | **□** None **□** 2 hours **□** 4 hours **□** 6 hours **□** 9 hours | Other: |
| Sitting | **□** None **□** 2 hours **□** 4 hours **□** 6 hours **□** 9 hours | Other: |
| Reaching | **□** None **□** 2 hours **□** 4 hours **□** 6 hours **□** 9 hours | Other: |
| Squatting | **□** None **□** 2 hours **□** 4 hours **□** 6 hours **□** 9 hours | Other: |
| Kneeling | **□** None **□** 2 hours **□** 4 hours **□** 6 hours **□** 9 hours | Other: |
| Stooping | **□** None **□** 2 hours **□** 4 hours **□** 6 hours **□** 9 hours | Other: |
| Bending Over | **□** None **□** 2 hours **□** 4 hours **□** 6 hours **□** 9 hours | Other: |
| Crawling | **□** None **□** 2 hours **□** 4 hours **□** 6 hours **□** 9 hours | Other: |
| Climbing | **□** None **□** 2 hours **□** 4 hours **□** 6 hours **□** 9 hours | What do you climb? |
| Driving | **□** None **□** 2 hours **□** 4 hours **□** 6 hours **□** 9 hours | What do you drive? |
| Lifting | **□** None **□** 2 hours **□** 4 hours **□** 6 hours **□** 9 hours | What do you lift/weight? |
| Carrying | **□** None **□** 2 hours **□** 4 hours **□** 6 hours **□** 9 hours | What do you carry/weight? |
| Pushing | **□** None **□** 2 hours **□** 4 hours **□** 6 hours **□** 9 hours | What do you push/weight? |
| Pulling | **□** None **□** 2 hours **□** 4 hours **□** 6 hours **□** 9 hours | What do you pull/weight? |
| Other: |
| How long can you **SIT** before your pain causes you to have to stand up? |  | Minutes/Hours |
| How long can you **STAND** before your pain causes you to sit/lay down? |  | Minutes/Hours |
| How long/far can you **WALK** before the pain causes you to stop? |  | Minutes/Hours/Blocks/Miles |

**CURRENT COMPLAINTS/ISSUES**

|  |
| --- |
| **□ NONE** – I have no current complaints to the injured area(s) |
|  |
| **AREA** | **COMPLAINT/SYMPTOM** |
| Neck | * Pain ☐ Stiffness ☐ Weakness ☐ Spasms ☐ Numbness ☐ Popping
 |
| Upper/Mid Back | * Pain ☐ Stiffness ☐ Weakness ☐ Spasms ☐ Numbness ☐ Popping
 |
| Low Back | * Pain ☐ Stiffness ☐ Weakness ☐ Spasms ☐ Numbness ☐ Popping
 |
| Left Shoulder | * Pain ☐ Stiffness ☐ Weakness ☐ Spasms ☐ Numbness ☐ Popping
 |
| Right Shoulder | * Pain ☐ Stiffness ☐ Weakness ☐ Spasms ☐ Numbness ☐ Popping
 |
| Left Elbow | * Pain ☐ Stiffness ☐ Weakness ☐ Spasms ☐ Numbness ☐ Popping
 |
| Right Elbow | * Pain ☐ Stiffness ☐ Weakness ☐ Spasms ☐ Numbness ☐ Popping
 |
| Left Wrist/Hand | * Pain ☐ Stiffness ☐ Weakness ☐ Spasms ☐ Numbness ☐ Popping
 |
| Right Wrist/Hand | * Pain ☐ Stiffness ☐ Weakness ☐ Spasms ☐ Numbness ☐ Popping
 |
| Left Hip | * Pain ☐ Stiffness ☐ Weakness ☐ Spasms ☐ Numbness ☐ Popping
 |
| Right Hip | * Pain ☐ Stiffness ☐ Weakness ☐ Spasms ☐ Numbness ☐ Popping
 |
| Left Knee | * Pain ☐ Stiffness ☐ Weakness ☐ Spasms ☐ Numbness ☐ Popping
 |
| Right Knee | * Pain ☐ Stiffness ☐ Weakness ☐ Spasms ☐ Numbness ☐ Popping
 |
| Left Ankle/Foot | * Pain ☐ Stiffness ☐ Weakness ☐ Spasms ☐ Numbness ☐ Popping
 |
| Right Ankle/Foot | * Pain ☐ Stiffness ☐ Weakness ☐ Spasms ☐ Numbness ☐ Popping
 |
| Other |  |
|  |
| **PAIN SCALE:** Please give us exact details about your pain - Please use the drawing scale below to describe your pain |



|  |  |
| --- | --- |
| What number best describes your pain scale as you sit here in this office RIGHT NOW? |  |
| What is the LOWEST pain level you have had since your injury/illness happened? |  |
| What is the HIGHEST pain level you have had since your injury/illness happened? |  |
| Is your pain constant? Are you in pain all of the time? | **□** Yes **□** No | Where? |
| Is your pain on and off? Comes and Goes? | **□** Yes **□** No | Where? |

|  |
| --- |
| **ACTIVITIES THAT INCREASE YOUR PAIN:** Please list all activities that make your pain WORSE |
| **□** Sitting for long periods of time | **□** Standing for long periods of time |
| **□** Walking | **□** Running |
| **□** Sleeping – Cannot sleep comfortably | **□** Bending/Squatting |
| **□** Pushing | **□** Pulling |
| **□** Reaching Overhead | **□** Lifting |
| **□** Carrying things from one place to another | **□** Sexual Activity |
| **□** Weather Changes | **□** Bowel Movements |
| **□** Any movement at all | **□** Other – Please explain |
|  |
| **ACTIVITIES OR MODALITIES THAT DECREASE YOUR PAIN:** Please list all activities that make your pain BETTER |
| **□** Physical therapy | **□** Massage therapy |
| **□** Chiropractic therapy | **□** Injections |
| **□** Prescription Medication(s) | **□** Over the counter medication(s) |
| **□** Rest/Sleep | **□** Exercise |
| **□** Cold packs | **□** Hot packs |
| **□** Nothing makes the pain better |  |
| **□** Other: |

**OTHER COMMENTS/CONCERNS**

PLEASE LIST ANY OTHER COMMENTS OR CONCERNS THAT YOU ARE HAVING AT THIS TIME:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I state that I have answered this questionnaire to the best of my ability and with information that is true and correct. I have received an Acknowledgement Form attached to this questionnaire that I have read, understand and signed as indicated by my signature below. If I required assistance to complete this form, all of the answers listed on this form are responses that I gave to the person that assisted me in filling out this form.

I have provided a current and valid phone number so that I can be reached if additional information is needed to complete my assessment. I have provided an email address and/or a fax number as indicated below so that my report can be submitted to me electronically.

**EXAMINEE PRINTED NAME:**

**EXAMINEE SIGNATURE:**