PSYCHOLOGICAL PATIENT QUESTIONNAIRE

Patient Information

RB PTP____ATTY____
DOCTOR Lyons DATE OF EVALUATION_____

PLEASE COMPLETE EVERY ITEM IN EACH SECTION

PATIENT NAME (NOMBRE)

_____
FIRST LAST

_____
ADDRESS

_____
CITY STATE ZIP

_____
HOME PHONE NUMBER/CELL PHONE NUMBER

SSN: _____-_____-_____

DOB: _____/_____ /_____ AGE: _____

MARITAL STATUS:
Single _____ Married _____ Divorced _____
Separated _____ Widowed _____
If Married, how long? _____

ETHNICITY:
Caucasian_____ Latino_____ Afro-Amer_____
Asian_____ Other_____

HT:_____ WT:_____

DOMINANT HAND: RIGHT/LEFT (circle one)

INSURANCE (ASEGURANZA)

_____
Insurance Carrier Name

_____
Address

_____
City

_____
Claim Number

_____
Phone Number

_____
Adjustor's Name

_____
Date of Injury

EMPLOYER (EMPLEADOR)
(where injury occurred)

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Are you still working? Yes No
Are you still an employee? Yes No
Last date worked: _____

PRIMARY TREATING PHYSICIAN- Workers Comp Doctor, not personal

Name: _____

Address: _____

_____

Phone Number: _____

ATTORNEY (ABOGADO)

Name: _____

Address: _____

City, State, Zip_____

Phone Number_____

_____
Occupation or Job Title

_____
Supervisor's Name

_____
Interpretation
Company_____

Interpreter's Name___ _____

PSYCHOLOGICAL INTAKE

Dear Patient/Injured Worker:

It is important in a workers' compensation case to establish a complete and accurate base of personal and historical information. This information often becomes a critical part of the decision making process in determining your case. Therefore, **your help and cooperation in answering this questionnaire as completely and accurately as possible is necessary and appreciated.** This is very important to the people involved in handling your case and for you to receive appropriate and fair compensation.

The amount of time, which has been scheduled for your interview appointment, does take into consideration that this has been done.

IF YOU NEED ADDITIONAL SPACE TO WRITE, PLEASE USE THE BACK OF THE PAGES

Interpreter used? ☐ Yes ☐ NO If Yes, what language? _____

Intake Interpreter's Name: _____License #:_____

Interpreter's Company: _____

Interview Interpreter's Name: _____ License #:_____

Interpreter's Company: _____

AUTHORIZATION FOR PSYCHOLOGICAL EVALUATION

By my signature affixed below, I hereby agree to participate in a psychological evaluation as part of my workers' compensation case. I understand that I am being seen for the purposes of an evaluation and that treatment may or may not be authorized by the workers' compensation insurance carrier in this case. I understand that this evaluation may include providing information about my emotional and physical state, either directly to the psychologist or through the use of psychosocial questionnaires or psychometric tests. I further understand that I may be asked to provide historical information regarding my personal, medical, mental health, or other such information. I understand that this information may be provided to my primary treating physician, my attorney, employer, insurance carrier, and other such parties involved in this litigation. I understand that all completed tests and reports are held in the offices of this clinic, and are the property of this company and not the psychologist. According to State and Federal law, I know that I have rights to these tests up to an appointed time. In agreeing to undergo this evaluation, I understand that the outcome cannot be determined ahead of time. The results may or may not suggest that I am experiencing any degree of emotional distress or that I have a diagnosable disorder. Furthermore, on rare occasions, individuals may experience discomfort or distress during or as a result of the evaluation. Should such an event take place. I will not hold the company or the evaluating psychologist liable. I understand that any recommendations made regarding current or future treatment are to be taken at my choice and discretion alone. Additionally, I understand that any treatment recommendations are not a promise to provide that treatment by the evaluating psychologist or by the clinic within which the evaluation was conducted. I understand that I can seek treatment elsewhere if I choose, and that I am free to seek independent evaluation(s) elsewhere or in addition to the current evaluation if I see lit, I also authorize the use of assessment information, without information identifying me, to be used for the purposes of research or evaluation of services provided.

I understand that most communication between a client and a psychologist is protected by law and that information about me can only be released with my permission except for the following: (1) when a patient represents a danger to oneself, (2) when a patient is a danger to others, (3) in incidents of suspected child or elder abuse/neglect, and (4) in the event of a court order. I have read, understand, and accept the above policies and consent to these psychological and psychiatric services. This may include psychological evaluations, neuropsychological testing, psychotherapy, biofeedback, medication consultation, or other services.

PATIENT SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provisions of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office. You can also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I MAY USE AND DISCLOSE YOUR PHI

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.

I can use and disclose your PHI without your consent for the following reasons:

1. **For treatment.** I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care.
2. **To obtain payment for treatment.** I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
3. **For health care operations.** I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws.
4. **Other disclosures.** I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but your are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Uses and Disclosures Do Not Require Your Consent.

I can use and disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state, or local law; judicial or administrative proceedings; or, law enforcement.** For example, I may make a disclosure to applicable officials when a law requires

me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.

2. **For public health services.** For example, I may have to report information about you to the county coroner.
3. **For health oversight activities.** For example, I may have to provide information to assist the government when it conducts and investigation or inspection of a health care provider or organization.
4. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical or psychological research.
5. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, I may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
6. **For specific government functions.** I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
7. **For workers' compensation purposes.** I may provide PHI in order to comply with workers' compensation laws.
8. **Appointment reminders and health related benefits or services.** I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization

In any other situation not described in sections HI A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you chose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI.
You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

B. **The Right to Choose How I Send PHI to You.** You have the right to ask that I send information to you at an alternate address (for example, sending information to your work address rather than to your home address) or by alternate means (for example, email instead of regular mail). I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

C. **The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PI-II but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you in writing my reasons for the denial and explain your right to have my denial reviewed.

D. The Right to Get a List of the Disclosures I Have Made.

You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family.

The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April l5, 2003.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PPH was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

E. The Right to Correct or Update Your PHI.

If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make change to your PPH, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by Email.

You have the right to get a copy of this notice by email. Even if you have agreed to receive this notice by email, you also have the right to request a paper copy of it.

V. HOW YOU COMPLAIN ABOUT MY PRIVATE PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003

_____ _____

Print Name Signature

_____

Date

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the confidentially medical information act of 1981, section 56 et. Seq., California civil code.

PATIENT: _____

DOB: _____ SSN#: _____

INFORMATION TO BE RELASED FROM:

Facility/Doctor's Name: _____

Address: _____

Phone#: _____ Fax#: _____

INFORMATION TO BE RELEASED TO: (Any and all medical reports – STAT)

By signing this form, I authorize you to release confidential health information about me by releasing a copy of all my medical records (including diagnostic studies), or a summary or narrative of my protected health information to the requested physician listed below:

Tigre Management, Inc.
Lawrence G. Lyons, PhD.
1950 E. 17th St., #235, Santa Ana, CA 92705
Tel: (714)587-8094 E-Fax: (760) 692-4810

For the purpose of: continuation of medical treatment (Worker's Compensation).

I am aware of and or have been advised of the provisions of existing state and federal statutes, rules, and regulations which provide for my right to confidentiality of the information in these records.

I realized that this is a required consent and that I must voluntary and knowingly sign this authorization before any records can be released, also that I may refuse to sign, but in that event the records cannot be released.

Date: _____

PATIENT SIGNATURE: _____

SIGNATURE OF PARENT/GUARDIAN: _____

RELATION TO PATIENT: _____

Authorization and Consent to the "Use of Electronic Signature" for the Independent Medical Review (IMR) Process (English)

I, _____ hereby request, authorize, and consent on (Date) _____ to the use, by my attorney or service provider or its designee (the "provider"), of my electronic signature provided below to file an Application for Independent Medical Review (DWC Form IMR) 1 ("IMR Application") when a treatment request is modified or denied by utilization review. I further request that the provider join with and assist me with the IMR Application. I understand that the provider is not obligated to assist me in the IMR application and may decline to do so for any reason in its sole discretion.

I authorize the use my electronic signature to obtain or cancel medical records or other information on my behalf required as part of the IMR process, including furnishing medical records and information relevant for review of the disputed treatment identified on an IMR Application to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury.

I understand that my electronic signature may not be invalidated solely on the basis that the signature was electronically obtained. I understand that I may rescind this authorization and consent at any time by providing written notice to the provider.

Autorizacion y Consentimiento al "Uso de la Firma Electr6nica" para el Proceso de Revision Medica Independiente (IMR) (Spanish)

Yo, _____ por la presente solicito, autorizo y consiento el (Fecha) _____ al uso, por mi abogado o proveedor de servicios o su designado (el "proveedor") de mi finna electronica proporcionada a continuacion para presentar una Solicitud de Revision Medica Independiente (Formulario DWC IMR)1 ("Solicitud de IMR") cuando una solicitud de tratamiento es modificada o negada por revision de utilizacion. Tambien solicito que el proveedor se una y me ayude en la presentacion de la Solicitud de IMR. Comprendo que el proveedor no esta obligado a ayudarme en la solicitud de IMR y puede negarse a hacerlo por cualquier raz6n a su sola discrecion.

Autorizo a usar mi firma electr6nica para obtener o terminado expedientes medicos u otra informacion en mi nombre requerida como parte del proceso de IMR, incluyendo la provision de registros medicos e informacion relevante para la revision del tratamiento disputado identificado en una Solicitud de IMR a la organizacion de revision medica independiente designada por el Director Administrativo de la Division de Compensacion de Trabajadores. Estos registros pueden incluir informes medicos, de diagnostico por imagenes y otros registros relacionados con mi caso. Estos registros tambien pueden incluir registros no medicos y cualquier otra informacion relacionada con mi caso, con excepcion de los registros relacionados con el estado de VIH, a menos que se declare que mi infeccion o exposicion al VIH es mi lesion laboral.

Entiendo que mi firma electronica no puede ser invalidada unicamente en base a que la firma fue obtenida electronicamente. Entiendo que puedo rescindir esta autorizacion y consentimiento en cualquier momento mediante notificaci6n por escrito al proveedor.

*Please sign in the center of the text box, not along the lines DOB: _____

** Por favor finne en el centro del cuadro de texto, no en las lineas SS: _____

form may vary from the current form.

2 Una copia del formulario IlvfR actual en el que se va a fijar su firma se puede encontrar en https://www.dir.ca.gov/dwc/DWCPropRe2:s/IMR/IMRFom1 Application.pdf. Tenga en cuenta que el formulario se puede modificar en el futuro, por lo que el fornnulario real puede variar de la forrna actual

California Judicial Council Certified Translation by Statewide Interpreters Corp 11-22-2016

NOTE: If your workers comp case involves <u>STRESS ONLY</u>, leave blank and go to the next page.

Please describe how the work injury occurred (i.e. the History of the Injury):

_____

_____

_____

_____

_____

_____

_____

What parts of your body were injured (if not listed above)? _____

_____

_____

What is your current source of income? ☐Work ☐ Work Comp Disability ☐EDD

☐General Relief ☐SSI ☐Welfare ☐Spouse ☐Retirement ☐Savings ☐None

_____

PAIN

Where is your current pain located? _____

_____

Please list any **surgeries** associated with this current work comp case and dates:

Type of Surgery	Date	Initial Response	Current Complications
For example: *Low back L4, L5 fusion*	*9/07*	*Good: less pain, able to do more activities*	*Flairs up at times, pain Averages a "2-4"*

STRESS AND/OR HARASSMENT HISTORY

NOTE: In order for your doctor to prepare a report for a stress type case, you must provide a very detailed history of all the stressful events that happened at work. If you have written or typed an outline, you can attach it to this history packet. The history should be presented in chronological order.

1. Does your workers com case involve supervisory harassment? YES/NO
   If yes, please describe in detail:

2. Does your workers comp case involve co-worker mistreatment or verbal bullying? YES/NO
   If yes, please describe:

3. Does your workers comp case involve being given an excessive amount of work? YES/NO
   If yes, please describe:

4. Does your workers comp case involve discriminatory treatment (i.e., based upon race, gender, or age)? YES/NO
   If yes, please describe:

5. Does your workers comp case involve being publically humiliated or dealing with workplace hostility? YES/NO
   If yes, please describe:

6. Does your workers comp case involve being verbally or physically threatened? YES/NO
   If yes, please describe:

Please list **CURRENT** medications:

Drug Name	Dose	Purpose	Length of Use	Response
For example: Tylenol	500mg/1xday	Low back pain	3 months	fair

TREATMENT TO DATE:

Treatment	Name of facility/Doctor	# of sessions	Comments
Physical Therapy			
Pool Therapy			
Epidural Steroid Injections			
Trigger Point Injections			
Facet Blocks			
Acupuncture			
Cortisone Injections			
Chiropractic Treatments			
Others			

****Comments Did it help? Did it reduce your pain? Did it help you move better?**_____

_____

SURGICAL PROCEDURE

NOTE: List any surgeries associated with this workers comp case.

Surgical Procedure	Date	Doctor	**Any Comments

*** Any comments: Did the surgery help in any way? Or did it make your condition worse? Please describe:**

_____
_____
_____

HAVE YOU DEVELOP ANY OTHER HEALTH PROBLEMS DUE TO THIS INJURY?

Medical Conditions	Yes/No	Date Diagnosed	Comments
1. High Blood Pressure			
2. High Blood Sugar			
3. Significant Weight Gain/Loss			
4. Drug Dependence			
5. Dizziness/Loss of Balance			
6. Ringing in the Ears			
7.Sleep Apnea			
8.Others			

PSYCHOLOGICAL TREATMENT ASSOCIATED WITH THIS WORKERS COMP CASE

1. Have you ever seen a prior psychologist or psychiatrist as part of your w/c case?
   YES/NO **(Circle one)**
   If yes, please describe:
   _____
   _____
   _____
   _____
   _____
2. Has any prior doctor prescribed antidepressant or antianxiety medication t as part of your w/c case?
   YES/NO **(Circle one)**
   If yes, please describe:
   _____
   _____
   _____
   _____
   _____
3. Have you had to go to a hospital emergency room due to anxiety or panic attack as part of your w/c case?
   YES/NO **(Circle one)**
   If yes, please describe:
   _____
   _____
   _____
   _____
   _____

BEHAVIOR CHANGES ASSOCIATED WITH YOUR INJURY OR DISABILITY PERIOD

Behavior Changes	YES/NO	If Yes, Please Describe
1.Increased Smoking		
2.Increased Alcohol Use		
3.Change in Food Consumption		
4.Increase Caffeine Use		
5.Decrease in Exercise		
6.Decrease in Sexual Relations		
7.Self-Injury Type Behaviors (i.e. hurting on self)		
8.Decreased in Grooming Standards		
9.Any Other Negative Behaviors		

SYMPTOMS & COMPLAINTS

Please CIRCLE any of the symptoms or problems you are having:

(A) DEPRESSIVE- TYPE SYMPTOMS

Sadness	Fatigue	Low Self-Esteem
Apathy (i.e., "I don't care")	Hopelessness	Loss of Pleasure Participating in Normal Activities
Avoid People/Friends	Lack of Motivation	Loss of Interest in Sex
Sleep Disturbance	Appetite Changes	Feel Empty Inside
Crying Episodes	Suicidal Thoughts (thoughts to kill self)	Thoughts of wanting to die but no thoughts of killing yourself

Note: If you have any depression, please answer the following:

(1) On a 1 to 10 scale with "1" being not depressed at all, and "10" being the most depressed you could ever imagine feeling, where do you generally rate your level of depression? (Please circle the number)

1 2 3 4 5 6 7 8 9 10

(2) Over the past few months, has your level of depression (circle one):

Became much worse Became worse Stayed the Same

Getting Better Getting Much Better

When did you notice feelings of depression start (estimated month/year)? _____

Has there been any days w/in the **last two weeks** when you didn't feel depressed? [] Yes [] No
In general, what percentages of each day are you depressed? Place an "X" anywhere below with your answer:

0%----|----|----|----|----25%----|----|----|----|----50%----|----|----|----|----75%----|----|----|----|----100%

In your own words, why are you depressed?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(B) **ANXIETY or PANIC-TYPE SYMPTOMS:**

Please **CIRCLE any of the symptoms or problems you are having:**

Feeling Insecure	Health Worries	Get anxious in crowds
Emotional Numbness	Visual Recollections of Injury	Flashbacks
Frequent Thoughts about the Injury	Nightmares and Fears Related to Injury	Feelings of Panic & Physical Trembling
Shortness of Breath	Excessive Perspiration	Fears of Dying
Dizziness	Chest Pains	Heart Palpitations
A Sense that Something Bad is going to Happen		

Note: If you have any Anxiety Symptoms, please answer the following:

(l) On a l to 10 scale with "l" being "not Anxious" at all and "10" being the most anxious you could ever imagine feeling, where do you generally rate your level of anxiety? (Please circle the number)

1 2 3 4 5 6 7 8 9 10

(2) Over the past few months, has your level of depression (circle one):

Became much worse Worse Stayed the Same

Getting Better Getting Much Better

When did you notice feelings of anxiety start? (estimated month/year)_____

In general, what percentage of each day are you anxious? Place an "X" anywhere below with your answer:

0%----|----|----|----|----25%----|----|----|----|----50%----|----|----|----|----75%----|----|----|----|----100%

(3) In your own words, please describe why you are experiencing anxiety.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(C) Has your ability to concentrate gotten worse since you injured yourself?
For example, having difficulty focusing your mind toward one particular task, idea, or subject.
Yes/No
If yes, please give an example

Do you feel like you've become more distracted since you injured yourself`?
For example, feeling like your thoughts, pain and/or feelings take attention away from something else.
Yes/No
If yes, please give an example

Have you experienced any short term memory problems since you injured yourself?
For example, you cannot retain information for very long.
Yes/No
If yes, please give an example

(D) Interpersonal Issues **(Circle all that apply to you):**

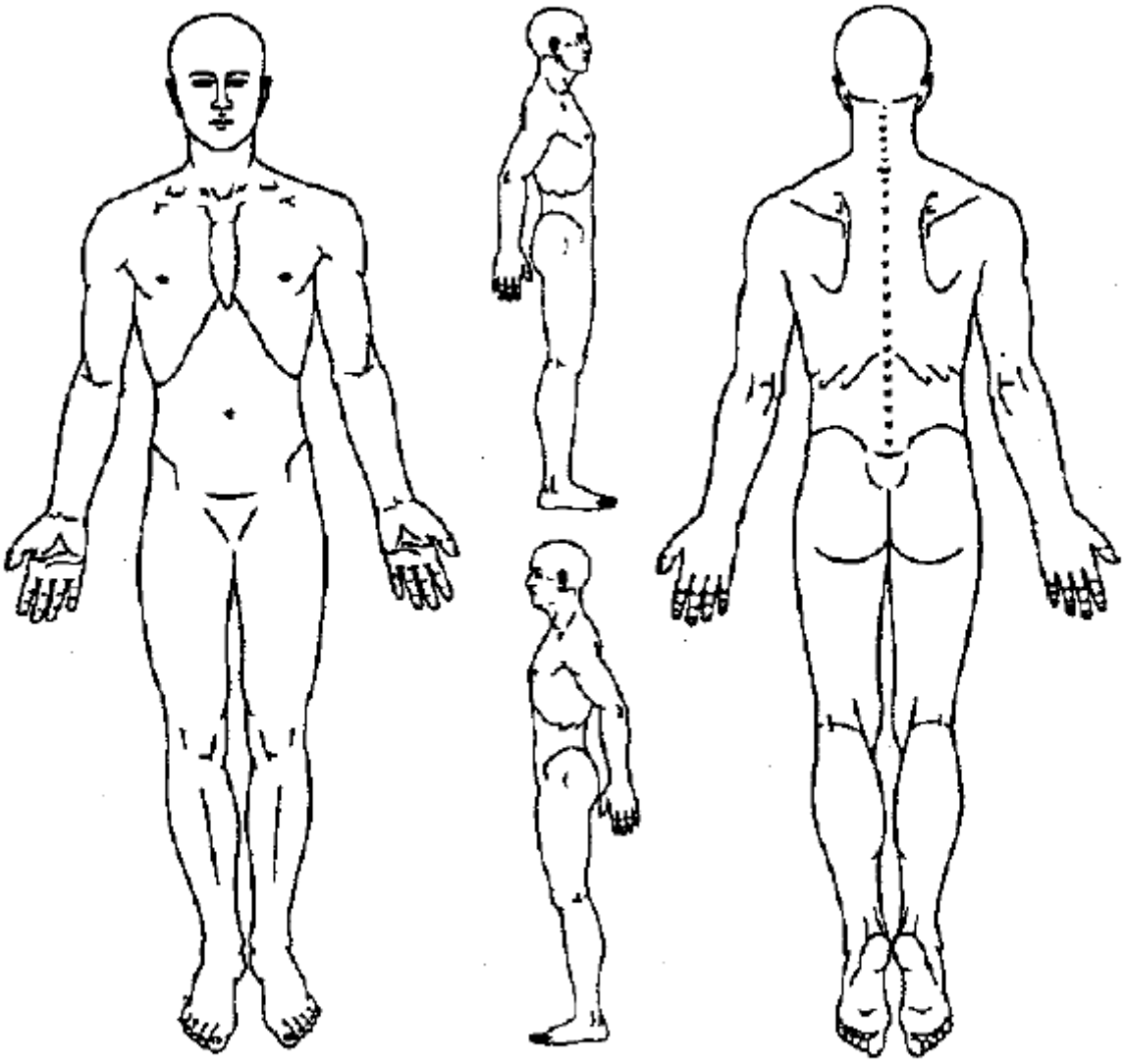
Irritable with others	Feels Timid and Insecure around People
Have Lost Trust In Others	Feels Like a Burden to Others
Avoid Friends and Family	Lose Temper Easily
Have Started to Yell & Curse	Feel Alone and Isolated

If you circled any of the above interpersonal problems, please provide any details or description on the lines below:

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: **A** – ACHE **B** – BURNING **N** – NUMBNESS
P – PINS & NEEDLES **S** – STABBING **O** - OTHER



PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

No Pain										Worst Possible Pain
0	1	2	3	4	5	6	7	8	9	10

PERSONAL PSYCHOSOCIAL HISTORY

FAMILY

Where were you born? _____ U.S. citizen: ☐Yes ☐ No
City, country (if not USA)

If not a U.S. citizen, in what year did you begin to permanently reside in the U.S.: _____

Who do you live with? _____

What do you live in? ☐ House ☐Apartment ☐Condo ☐Trailer ☐Other

Have you ever been homeless? ☐ No ☐Yes If yes, when? _____

FAMILY OF ORIGIN

Father's Age: _____ Level of Education: _____ Occupation: _____

Mother's Age: _____ Level of Education: _____ Occupation: _____

☐ Father deceased _____ year _____ Cause of death

☐ Mother deceased _____ year _____ Cause of death

Who were you raised by ☐ Mom ☐Dad ☐ Grandparents ☐Aunt/Uncle

Are your parents still married? ☐Yes ☐ No ☐Divorced ☐Never married ☐Deceased
Married until _____ deceased
Your age when marriage ended (if applicable): _____years old.

Were you adopted? ☐No ☐Yes If yes, at what age? _____

How many sisters? _____ How many brothers? _____

Step / Half-sisters? _____ Step / Half-brothers? _____

Your position in birth order: ☐Youngest ☐Middle ☐Oldest

How would you describe your childhood? ☐Good ☐Loving ☐Okay ☐Strict ☐Dysfunctional

Any history of traumas or abuse including physical abuse, sexual abuse, or domestic violence?

☐ No ☐Yes (describe) _____

Any family history of mental illness? ☐Yes ☐ No
If yes, **who** and what is their **diagnosis**? _____

Any family history of medical conditions? (i.e. diabetes, hypertension, cancer, thyroid)

_____

How would you describe your relationship with your family now (your parents & siblings)?

☐Very close ☐Good ☐Strained ☐Distant ☐Poor

FAMILY OF PROCREATION

If married (or Cohabitate), how long have you been married (living together,)? _____years

Have you been married more than once? ☐No ☐Yes If yes, how many times? _____

If you've never been married, how long was your longest relationship? _____

How is your marriage (relationship)? ☐Excellent ☐Good ☐Fair ☐Poor ☐Strained due to injury

What is your spouse's . . .

Age: _____ Level of Education: _____ Occupation: _____

How many children do you have?

#Boys _____ Ages: _____ #Girls_____ Ages: _____

#Step-Sons: _____ Ages: _____ #Step-Daughters: _____ Ages: _____

How many children live with you? _____

How is your relationship with your children? ☐Excellent ☐Good ☐Fair ☐Distant

☐Poor ☐Strained due to injury

EDUCATION

What was the highest grade ***completed*** in school? _____ grade

If you attended school past 9th grade, what High School did you go to? _____

If you graduated High School, what year was it? _____

Did you attend college? ☐Yes ☐ No ☐Graduated or # of years: _____

Name of College: _____ Major: _____

Degree: ☐ AA ☐BA/BS ☐MA/MS ☐Ph.D. /J.D. _____

How did you do in school? ☐Above average ☐Average ☐Below Average ☐Poorly

Did you have any behavioral problems at school? ☐None ☐Fighting ☐Disrupted classroom

☐Truancy _____

Did you have any learning problems? ☐ No ☐Yes _____

Were you in Special Education classes? ☐ No ☐Yes If Yes, since what grade? _____

Did you take any professional, technical, or vocational training classes? ☐ No ☐Yes

If yes, what did you take? _____

Past Medical History:

Prior Automobile Accidents: ☐Yes ☐ No. If Yes, Describe:

_____
_____
_____

Prior work-related Injuries: ☐Yes ☐ No. If Yes, Describe:

_____
_____
_____

Prior Serious Injuries/Trauma: ☐Yes ☐ No If Yes, Describe:

_____
_____
_____

Prior Hospitalizations: ☐Yes ☐ No If Yes, Describe:

_____
_____
_____

Prior Surgical Procedures: ☐Yes ☐ No If Yes, Describe:

_____
_____
_____

Prior Significant Illnesses or Diseases: ☐Yes ☐ No If Yes, Describe:

_____
_____
_____

Mental Health History:

Prior Psychological Counseling: ☐Yes ☐ No. If Yes, Describe:

_____
_____
_____

Prior Medication Treatment For Depression: ☐Yes ☐ No If Yes, Describe:

_____
_____

_____

Prior Psychiatric Hospitalization/Suicide: ☐Yes ☐ No. If Yes, Describe:

_____
_____
_____

Prior Substance Abuse/Alcohol History: ☐Yes ☐ No. If Yes, Describe:

_____
_____
_____

EMPLOYMENT/WORK HISTORY:

PREVIOUS WORK EXPERIENCE

Previous Employers	Start Date	End Date	Job Title	Promotional Mobility	Reason for Leaving	Accomplishments
				☐ Up ☐ Down ☐ Lateral		
				☐ Up ☐ Down ☐ Lateral		
				☐ Up ☐ Down ☐ Lateral		
				☐ Up ☐ Down ☐ Lateral		

Ever served in the military? ☐ No ☐ Yes If so, dates of service & rank: _____

Combat Experience: ☐ No ☐ Yes Discharged: ☐ No ☐ Yes _____

Did your work experience ever include any of these job responsibilities?

- Supervising others in their work. ☐Yes ☐ No
- Training others that were new to the job. ☐Yes ☐ No
- Interacting with customers and handling orders or complaints. ☐Yes ☐ No
- Operating a computer. ☐Yes ☐ No
- Handling money, checks, and/or credit card transactions. ☐Yes ☐ No
- Acquiring knowledge from a manual or other such source. ☐Yes ☐ No
- Writing reports. ☐Yes ☐ No
- Participating in trainings. ☐Yes ☐ No

• Earning a certificate or state license. ☐Yes ☐ No

Relevant Legal History:

Prior Arrests and/or Incarcerations: ☐Yes ☐ No If Yes, Describe:

_____
_____
_____

Prior Workers Compensation Claims: ☐Yes ☐ No If Yes, Describe:

_____
_____
_____

Personal Injury Lawsuits: ☐Yes ☐ No If Yes, Describe:

_____
_____
_____

.

Filing Bankruptcies: ☐Yes ☐ No If Yes, Describe:

_____
_____
_____

PAST TRAUMA HISTORY

As a child or adolescent, were you ever physically abused? _____YES _____NO
If yes, please explain: _____
_____
_____

As a child or adolescent, were you ever sexually abused? _____YES _____NO
If yes, please explain: _____
_____
_____

As a child, were you ever emotionally abused or suffered from neglect? _____YES _____NO
If yes, please explain:_____
_____
_____

As an adult, have you ever been the victim of a physical assault? _____YES _____NO
If yes, please explain:_____
_____

As an adult, have you ever been the victim of a sexual assault? _____YES _____NO

If yes, please explain:

_____

Have you been involved in a domestic violence situation? _____YES _____NO
If yes, please explain: _____

_____

EDUCATIONAL HISTORY

1. NUMBER OF YEARS YOU ATTENDED SCHOOL _____
2. WHAT CITY/STATE OR COUNTY DID YOU ATTEND SCHOOL _____
3. WHAT HIGH SCHOOL DID YOU ATTEND (IF APPLICABLE) _____
4. IF COMPLETED, WHAT YEAR DID YOU GRADUATE _____
5. WHERE YOU IN ANY SPECIAL EDUCATION CLASSES _____
6. IF SO, WHAT TYPE OF SPECIAL EDUCATION CLASSES _____
7. WERE YOU EVER DIAGNOSED WITH ATTENTION DEFICIT _____
8. DID YOU HA VE ANY SPEECH PROBLEMS _____
9. WERE YOU EVER DIAGNOSED WITH HYPERACTIVITY _____
10. DID YOU HA VE TO REPEAT ANY GRADES _____
11. WERE YOU EVER SUSPENDED FROM SCHOOL _____
12. WERE YOU EVER EXPELLED FROM SCHOOL _____
13. WHAT GRADES DID YOU EARN IN SCHOOL _____
14. WERE YOU EVER ON THE HONOR ROLL _____
15. DID YOU A TIEND ANY COLLEGE _____
16. IF SO, WHAT COLLEGE(S) _____
17. DID YOU EARN ANY COLLEGE DEGREE (S) _____
18. IF SO, WHAT COLLEGE DEGREE DID YOU EARN _____
19. WHAT YEARS DID YOU ATTEND COLLEGE _____
20. WHAT YEAS DID YOU GRADUATE _____
21. WHAT WAS YOUR COLLEGE MAJOR _____

22; AFTER YOU LEFT SCHOOL, WHAT DID YOU DO _____

LEVELS OF PERMANENT MENTAL IMPAIRMENT

As identified in Table 14-1 of the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition:

Rating 1. No Problem
Rating 2. Mild Permanent Problem
Rating 3. Moderate Permanent Problem
Rating 4. Marked Permanent Problem
Rating 5. Extreme Permanent Problem

1. Activities of Daily Living

	Self-care personal hygiene (urinating, defecating, brushing teeth, combing hair, dressing himself, bathing, eating, preparing meals, and feeding oneself)
	Communication (writing, typing, seeing, hearing, speaking)
	Physical Activity (standing, sitting,, reclining, walking, climbing stairs)
	Travel (driving, riding, flying)
	No specialized hand activities (grasping, lifting, tactile discrimination)
	Sexual function (orgasm, ejaculation, lubrication, erection)
	Sleep (restful, nocturnal sleep pattern)

- My level of depression is at a level that has led to disinterest in maintaining personal grooming standards (e.g., washing, brushing teeth, etc.) (Circle One) Yes/ No
  If yes, Please describe: _____
  _____
  _____

- My level of physical pain keeps me from maintaining personal grooming standards?
  (Circle One) Yes/ No
  If yes, Please describe:_____
  _____
  _____

  My ability to travel and operate a vehicle has been compromised by fatigue, decreased alertness, and medication usage. (Circle One) Yes/ No
  If yes, Please describe: _____
  _____
  _____