MEDICAL EVALUATION FORM

DOCTOR: _____ SPECIALTY: _____

PHONE: _____ FAX: _____

ADDRESS: _____

_____

PATIENT NAME: _____

SOCIAL SECURITY NUMBER: _____ SEX: _____

DATE OF BIRTH: _____ AGE: _____

DATE PATIENT FIRST SEEN: _____ DATE PATIENT LAST SEEN: _____

FREQUENCY OF VISITS: _____

1. DIAGNOSIS(ES), LIST ALL CONDITIONS: _____

   _____

   _____

2. SYMPTOMS AND OBJECTIVE TESTS SUPPORTING PATIENT'S SYMPTOMS: _____

   _____

   _____

3. HOSPITALIZATIONS AND SURGERIES: _____

   _____

   _____

4. LIST MEDICATIONS AND WHETHER MEDICATIONS CONTROL CONDITION(S): _____

   _____

   _____

   _____

   _____

   _____

   _____

_____

5. DOES PAIN, FATIGUE OR THE SIDE EFFECTS OF MEDICATION INTERFERE WITH YOUR PATIENT'S ABILITY TO CONCENTRATE OR RETAIN ALERT AT ANY JOB?

   YES: _____ NO: _____

6. IF YES, PLEASE ESTIMATE ON THE AVERAGE HOW OFTEN YOUR PATIENT'S CONCENTRATION LEVEL IS AFFECTED BY THE ABOVE SYMPTOMS:

   _____ N/A

   _____ OCCASIONALLY (OCCURRING UP TO 1/3 OF AN 8-HOUR WORK DAY)

   _____ FREQUENTLY (OCCURRING FROM 1/3 TO 2/3 OF AN 8-HOUR WORK DAY)

   _____ REPETITIVELY (OCCURRING MORE THAN 2/3 OF AN 8-HOUR WORK DAY)

7. WOULD YOUR PATIENT'S SYMPTOMS LIKELY INCREASE IF HE/SHE WERE PLACED IN A COMPETITIVE WORK ENVIRONMENT?

   YES: _____ NO: _____

8. DOES YOUR PATIENT'S CONDITION INTERFERE WITH THEIR ABILITY TO KEEP THE NECK IN A CONSTANT POSITION (IE. LOOKING AT A COMPUTER/LOOKING DOWN AT DESK) ON A SUSTAINED DAILY BASIS DURING AN 8-HOUR WORK DAY?

   YES: _____ NO: _____

9. IS YOUR PATIENT ABLE TO SLEEP THROUGH THE NIGHT?

   YES: _____ NO: _____

10. DO EMOTIONAL FACTORS CONTRIBUTE TO THE SEVERITY OF YOUR PATIENT'S SYMPTOMS AND FUNCTIONAL LIMITATIONS?

    YES: _____ NO: _____

11. IS YOUR PATIENT A MALINGERER?

    YES: _____ NO: _____

12. WOULD YOUR PATIENT BE ABLE TO WORK AT LEAST 6 HOURS OF AN 8 HOUR DAY ON A SUSTAINED DAILY BASIS?

    SIT ONLY YES: _____ NO: _____

    STAND ONLY YES: _____ NO: _____

ALTERNATE SIT/STAND YES: _____ NO: _____

13. HOW MANY HOURS DOES YOUR PATIENT NEED TO REST THROUGHOUT AN 8-HOUR DAY?

    0-2 HRS: _____ 3-5 HRS: _____

    4-6 HRS: _____ 7-8 HRS: _____

14. WILL YOUR PATIENT SOMETIMES NEED TO TAKE UNSCHEDULED BREAKS OR REST AT UNPREDICTABLE INTERVALS DURING AN 8-HOUR WORK DAY?

    YES: _____ NO: _____

15. HOW MANY POUNDS CAN YOUR PATIENT LIFT AND CARRY FREQUENTLY DURING AN 8-HOUR WORK DAY ON A SUSTAINED DAILY BASIS?

    1-5 LBS: _____ 6-10 LBS: _____

    11-20 LBS: _____ 21-25 LBS: _____

    26-50 LBS: _____ 50-100 LBS: _____

    NO FREQUENT LIFTING: _____

16. CAN YOUR PATIENT USE HIS/HER ARMS/HANDS FREQUENTLY FOR GRASPING, PULLING, PUSHING OR FINE MANIPULATION AT WORK FOR 8 HOURS ON A SUSTAINED DAILY BASIS?

    YES: _____ NO: _____

17. CAN YOUR PATIENT USE HIS/HER LEGS TO PUSH OR PULL FREQUENTLY DURING AN 8-HOUR WORK DAY ON A SUSTAINED DAILY BASIS?

    YES: _____ NO: _____

18. CHECK THE ACTIONS BELOW THAT THE PATIENT IS ABLE TO PERFORM DURING AN 8-HOUR WORK DAY ON A SUSTAINED DAILY BASIS:

    _____ BENDING

    _____ SQUATTING

    _____ KNEELING

    _____ CLIMBING

    _____ REACHING

    _____ GRIPPING/GRASPING

_____ FREQUENT FINE MANIPULATION

19. SHOULD PATIENT AVOID EXPOSURE AT WORK TO ANY OF THE FOLLOWING (CHECK THOSE THAT APPLY):

_____ UNPROTECTED HEIGHTS

_____ DUST, FUMES & GASES

_____ SCENTED PRODUCTS (PERFUME, COLOGNE, CLEANING PRODUCTS, ETC.)

_____ MOVING MACHINERY

_____ MARKED CHANGES IN TEMPERATURE/HUMIDITY

_____ DRIVING AUTOMOTIVE EQUIPMENT

_____ FLUORESCENT LIGHTS

_____ LOUD NOISE

20. ARE YOUR PATIENT'S IMPAIRMENTS LIKELY TO CAUSE "GOOD DAYS" AND "BAD DAYS"?

YES: _____ NO: _____

21. IF YES, PLEASE ESTIMATE ON THE AVERAGE HOW OFTEN YOUR PATIENT IS LIKELY TO BE ABSENT FROM WORK AS A RESULT OF THE IMPAIRMENTS OR TREATMENT(S)?

_____ NEVER

_____ UP TO 1 TIME A MONTH

_____ 2 TIMES A MONTH

_____ 3 TIMES A MONTH

_____ 4-5 TIMES A MONTH

_____ OVER 5 TIMES A MONTH

22. DOES YOUR PATIENT NEED A JOB THAT PERMITS READY ACCESS TO A RESTROOM THROUGHOUT THE DAY?

YES: _____ NO: _____

23. PROGNOSIS: _____

DOCTOR SIGNATURE: _____

DOCTOR NAME: _____

DATE: _____

*FREQUENTLY MEANS OCCURRING ONE TO TWO THIRDS OF AN 8-HOUR WORK DAY, CUMULATIVE NOT CONTINUOUS