Information & Instructions About Your IME

I understand that I am here for an independent medical examination (IME), which means the doctors(s) performing the evaluation is neither treating me nor an employee of whomever requested the IME (insurance company, third party administrator, attorney, governmental agency, employer, or physician). I understand the purpose of the independent medical examination is to provide a thorough, objective evaluation of the specific condition(s) related to my injury or illness which is in question, as well as prior subsequent conditions that might affect it, and to answer whatever questions the requesting party has. This sheet outlines the process, my rights, and my responsibilities.

This IME is **not** a comprehensive medical examination. I understand it **will not** provide advice or treatment to me or substitute for evaluation or treatment by my regular treating doctor. I understand a patient/physician relationship is not established between the evaluating physician and me. Accordingly, there is no patient/physician privilege associated with this evaluation. Usually a written report will be prepared summarizing today's evaluation and sent to the requesting party.
If I would like a copy of the report, I will contact them.

I understand that generally the evaluation will begin with the doctor obtaining a history of how my problem began and what evaluation or treatment has been rendered since. Utilizing information I provide verbally and on the history forms, as well as that contained within whatever records may be available for review. The doctor well then ask about my current symptoms and record a relatively brief past medical and other information such as my work status, etc. All information which I provide may be included in the report.

After the interview, a physical examination of the relevant body part(s) will be conducted. I understand that I need not perform any maneuver I feel might cause injury or a worsening of my symptoms, and will immediately inform the examiner if anything he is doing is causing excessive discomfort so it can be stopped right away. Some pain, stiffness, or other symptoms are produced in most physical examinations of this sort. For instance, when touching a tender spot or checking how far a stiff joint can move, and such findings are helpful in understanding the condition. The IME, however, is not intended to cause injury or excessive pain. I understand that in order to avoid that I must fulfill my responsibility to inform the doctor(s) if there is something I can't do, a certain test is causing too much discomfort, etc.

I also understand that I will be permitted to have a family member or friend, who is not a licensed clinical practitioner, present during the physical examination . It may be necessary to obtain additional x-rays or other diagnostic tests in order to answer certain question. These may be performed here or at another facility.

I have read and understand the aforementioned information and instructions . I authorize this physician or any co-examiner to obtain any information that may be of relevance to the condition(s) in question, and to release that information and the results of the IME (verbally or in writing) to any entity who has requested the IME.

_____ _____

Signature Date

_____

Printed Name

Independent Medical Evaluation Questionnaire

We will be seeing you soon for your independent medical evaluation. We pledge that we will be both thorough and impartial. During this visit no treating physician/patient relationship will be established. The purpose of this visit is to answer specific questions concerning your case and to prepare a report. The information that you share with us will be included in the report. **If anyone else needs a copy of this report, it is required that they obtain it directly from the organization requesting this evaluation.**

During the visit we will review your history, medical records, and any available studies. We will also perform a physical examination. If you have any difficulties whatsoever during the assessment you should let us know immediately. To adequately understand your case, we need to carefully review your history. Please complete this questionnaire and bring it with you to the examination. We will review all of this information at the time of your visit. We look forward to seeing you.

1. What is your full name? _____
2. What is your date of birth? _____ /_____ / _____
3. Are you: Right Handed _____ Left Handed _____ Either _____
4. What is the date of your injury? _____ / _____ / _____
5. Have you ever had any previous problems or injuries, including any other work-related, recreational, or motor vehicle injuries? Yes _____ No _____
   If yes please explain _____

   _____
6. Have you ever had any difficulties prior to the date of your injury that were similar to those you are now experiencing? Yes _____ No _____
7. Please describe how your injury occurred: _____

   _____

   _____
8. What problems did you have at that time? _____

   _____
9. What did you do following the injury? _____

   _____
10. Briefly describe what has occurred since that time until now: _____

    _____

    _____
11. What is your greatest concern at this time? _____

    _____

***If you are not having difficulty with pain, proceed to question 18.**

12. Where is your pain located? _____

13. How would you describe your pain? _____

_____

14. What makes your pain worse? _____

15. What puts your pain at ease? _____

16. How frequent is your pain? Constant _____
Frequent _____
Occasional _____
Intermittent _____

17. On a scale from 0 (no pain) to 10 (excruciating pain):
*What number would you put on your pain at this time? _____
*During the past month, what has it averaged? _____
*During the past month, what is the highest it has been? _____
*During the past month, what is the lowest it has been? _____

18. Are you having any other difficulties? Yes _____ No _____ Not sure _____
If yes please describe these difficulties in detail _____

_____

_____

19. Are any tasks difficult for you to perform? Yes _____ No _____ Not sure _____
If Yes, please describe the tasks that are most difficult for you: _____

_____

***If your injury is not work-related, please proceed to question 28.**

20. Who were you employed by when you were injured? _____

21. How long had your been working there? _____

22. What was you job? _____

23. What did this job involve? _____

_____

_____

24. What type of work have you performed previously? _____

_____

25. What is your level of education? _____

26. Are you working now? Yes _____ No _____

27. Has your doctor, or anyone prescribed any work restrictions?
Yes _____ No _____ Not sure _____

28. Where do you live? _____

29. Who lives with you? _____

30. Please describe your typical day: _____

_____

_____

31. Are you involved in any work activities or any significant recreational pursuits?
Yes _____ No _____ Not sure _____

If yes, please describe: _____

_____

32. Are you or have you ever been a smoker? No _____ Yes _____ How many packs per day?_____

Yes but I quit _____ Months _____Years ago

33. How many alcoholic beverages do you have per week? _____

34. Have you had any medical hospitalizations? Yes _____ No _____ Not sure _____

If yes, please describe: _____

_____

35. Have you had any operations? Yes _____ No _____ Not sure _____

If yes, please describe: _____

_____

36. Are you taking any prescribed medications? Yes _____ No _____ Not sure _____

If yes, please describe: _____

_____

37. Are you allergic to any medications? Yes _____ No _____ Not sure _____

If yes, please describe: _____

38. Have you had any other medical problems? Yes _____ No _____ Not sure _____

If yes, please describe: _____

39. Do any diseases run in your family?Yes _____ No _____ Not sure _____
If yes, please describe: _____

_____

40. Please provide any other comments that may assist us in understanding your situation:

_____

_____

I understand that I am being seen for an independent medical evaluation and no treating physician/patient relationship is established. I understand that the information I discuss will be included in a report that is prepared for the requesting client. I consent to this report being sent to this client and to participating in the assessment. I agree to advise the physician immediately if I experience any difficulties during the examination.

Signed: _____ Date: _____

Name: _____

Date: _____

Pain Drawing

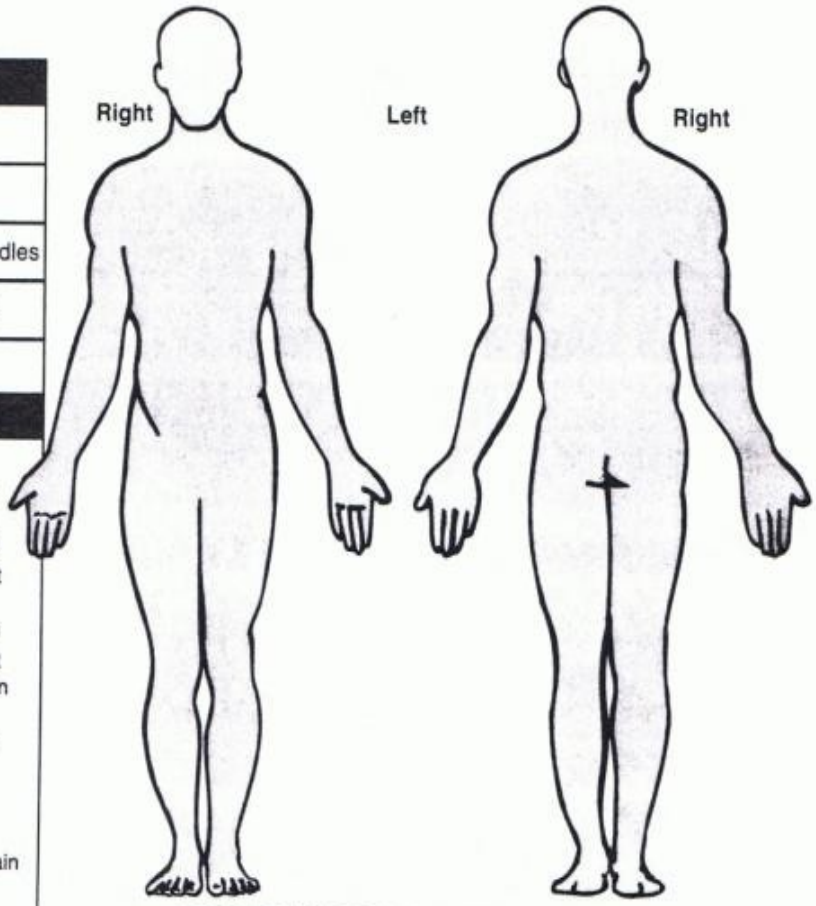
Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

☐ RIGHT HANDED

☐ LEFT HANDED

KEY	
///////	Stabbing
XXXX	Burning
0000	Pins & Needles
====	Numbness
++++	Aching

PAIN LEVEL	
0	No pain
1	Mild pain; you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; it may make you contemplate suicide



CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

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