Physician's Questionnaire

To:

Re:

Please answer the following questions concerning your patient's impairments:

1. Diagnoses:_____

_____

_____

_____

2. Clinical Signs/Symptoms: _____

_____

_____

3. Identify any positive objective signs of your patient's physical impairments:

☐ SLR left at _____%	☐ tenderness	☐ weight change	☐ joint warmth
☐ SLR right at _____%	☐ crepitus	☐ sensory changes	☐ joint coldness
☐ swelling	☐ reflex changes	☐ motor loss	☐ joint deformity
☐ muscle spasm	☐ impaired sleep	☐ impaired appetite	☐ joint instability
☐ muscle weakness	☐ atrophy	☐ chronic fatigue	☐ abnormal gait
☐ deep pressure pain	☐ trigger points	☐ air causes pain	☐ abnormal posture
☐ pitting edema	☐ depression	☐ anxiety	☐ burning sensation
☐ abnormal sweating	☐ vasoconstriction/vasodilation		☐ tingling/numbness
☐ perception of temperature causes pain		☐ light touch causes pain	
☐ trophic skin changes (e.g. skin atrophy, hyperhidrosis)			☐ vasomotor instability

4. Identify any other positive clinical findings and test results:

_____

_____

5. If your patient exhibits **limitation of motion**,

   a. please indicate range of motion for the affected area(s) of the spine:

	Lumbar	**Cervical**	**Thoracic**
extension	_____%	_____%	_____%
flexion	_____%	_____%	_____%
lateral flex-right	_____%	_____%	_____%
lateral flex-left	_____%	_____%	_____%
rotation	_____%	_____%	_____%

   b. and range of motion for affected area(s) not listed above:

_____

_____

6. Characterize the severity of your patient's **pain or paresthesia**:_____

and identify the **location and frequency**:_____

_____

Questions 7 through 11 assume your patient would be placed in a competitive work setting for an 8-hour workday. "Rarely" means 1% to 5% of an 8-hour work day, "occasionally" means 6% to 33% of an 8-hour work day, and "frequently" means 34% to 66% of an 8-hour work day.

7. If your patient experiences symptoms which interfere with **attention and concentration**, please estimate the **frequency** of interference: ☐ never ☐ rarely ☐ occasionally ☐ frequently ☐ constantly

8. Identify those aspects of **workplace stress** that your patient would be **unable to perform or be exposed to**:
   - ☐ public contact
   - ☐ interaction with coworkers
   - ☐ instruction from supervisors
   - ☐ routine, repetitive tasks at consistent pace
   - ☐ detailed or complicated tasks
   - ☐ strict deadlines
   - ☐ fast paced tasks (e.g., production line)
   - ☐ exposure to work hazards (e.g., heights or moving machinery)
   - ☐ other:_____

9. Estimate your patient's functional limitations resulting from his/her impairment(s):

   a. How far can your patient **walk** without rest or increased pain?

   _____

   b. How long can your patient **sit** in an 8-hour workday with normal breaks?

   _____

   c. How long can your patient **stand** in an 8-hour workday with normal breaks?

   _____

   d. If your patient needs to **use a cane or other assistive device**, please describe when he/she must use it and the date on which its use was first suggested or prescribed:

   _____

   _____

   e. If your patient would need to take unscheduled breaks, please indicate how often and for how long:

   _____

   f. Should your patient's legs be elevated? ☐ Yes ☐ No
   If yes, how high?_____
   how often each day?_____
   for how long each time?_____

g. How many pounds can your patient **lift and/or carry**:

	Never	Rarely	Occasionally	Frequently	Constantly
Less than 10 lbs.	☐	☐	☐	☐	☐
10 lbs.	☐	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐	☐

h. If your patient has postural limitations, please indicate the frequency with which he/she can:

	Never	Rarely	Occasionally	Frequently	Constantly
Climb ramps	☐	☐	☐	☐	☐
Climb stairs	☐	☐	☐	☐	☐
Climb ladders	☐	☐	☐	☐	☐
Climb ropes	☐	☐	☐	☐	☐
Climb scaffolds	☐	☐	☐	☐	☐
Balance	☐	☐	☐	☐	☐
Stoop/bend	☐	☐	☐	☐	☐
Kneel	☐	☐	☐	☐	☐
Crouch	☐	☐	☐	☐	☐
Crawl	☐	☐	☐	☐	☐

10. Please indicate the percentage of time your patient is able to use his/her hands, fingers, and arms:

	Left	**Right**
Hands (grasp, turn, twist objects)	_____%	_____%
Fingers (fine manipulations)	_____%	_____%
Arms (reaching overhead)	_____%	_____%
Arms (reaching in front)	_____%	_____%

11. Please estimate how often your patient likely would miss work, arrive late, or leave early in an average month because of impairment(s) and treatment.

_____

12. Have your patient's impairments lasted or can they be expected to last at least 12 months? ☐ Yes ☐ No

13. Is your patient malingering? ☐ Yes ☐ No

14. Is alcohol or drug abuse an impairment that significantly affects your patient? ☐ Yes ☐ No

If yes, would these symptoms be less severe if your patient stopped using drugs or alcohol? ☐ Yes ☐ No

Please describe what symptoms and limitations would remain if your patient stopped using drugs or alcohol:

_____

_____

_____

15. Does your practice offer times on weekends or after hours for regularly-scheduled appointments? ☐ Yes ☐ No

16. Additional comments: _____

Regarding Qualifications as Treating Physician:

Have you examined the patient often enough to obtain a view over time of the patient's medical conditions, abilities, and limitations, to a reasonable degree of medical certainty? ☐ Yes ☐ No

Is your knowledge of the nature and severity of the patient's conditions and limitations based on your examinations, patient's response to treatment, and results of examinations or testing that you have ordered? ☐ Yes ☐ No

First Date Examined: _____ Last Date Examined: _____

Board Certification: _____

Other Specialties: _____

_____ _____

Today's Date *Signature*

Printed/typed name: _____

Address: _____