Alan Kimelman MD
Qualified Medical Evaluator, AME
Diplomat, American Board of Electrodiagnostic Medicine (EMG)
Diplomat, American Board of Physical Medicine & Rehabilitation

Qualified Medical Evaluation Questionnaire

Thorough, accurate, legible responses support the doctor's ability to provide a comprehensive evaluation of your injury.

- ***Please take your time to complete this questionnaire. This may take a while.***
- ***We suggest you complete this as soon as possible to return to us. Details are important.***
- ***If possible, please copy or take pictures of the questionnaire in case of loss in the mail.***
- ***Pictures of the injury site and of your injury, if available, are helpful.***
- ***Email Questionnaire to ma@kimelmanmd.com***
- ***Mail Questionnaire to 4 Florida Street.***
  - ***If mailed, please send 4 business days before scheduled appointment***

Although Dr. Kimelman is a physician and you have a medical condition, this evaluation is governed by the California Labor Code on Medical-Legal Evaluations and does not establish a physician-patient relationship.

Personal Information

Name: _____ Date of Birth: _____

Current Mailing Address: _____

City: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Attorney's Name: _____ Attorney's Phone: _____

Claim #: _____

Height: _____ Weight: _____ lbs. Handedness (check): ❑Right ❑Left

History of Injury

Describe how the injury occurred (in terms of: reaching, bending, squatting, gripping)

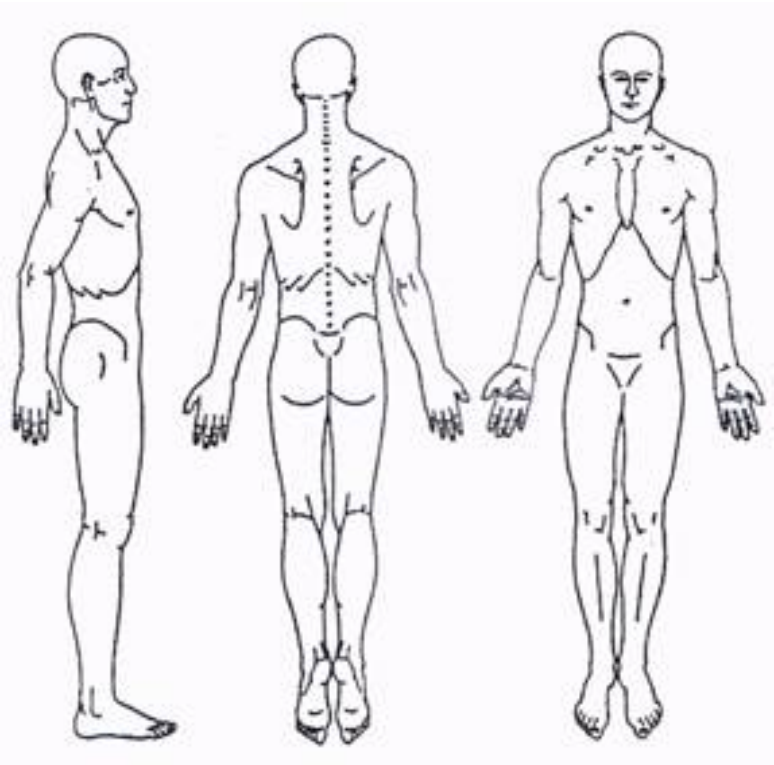
Please complete the following tables regarding the injury for which you are being evaluated

Date of Injury	Body Part (Strain, sprain dislocation, fracture)	Onset of Pain Gradual / Sudden	Employer at Time of Injury	Date Injury Reported	Date of First Treatment	Dates Missed Work

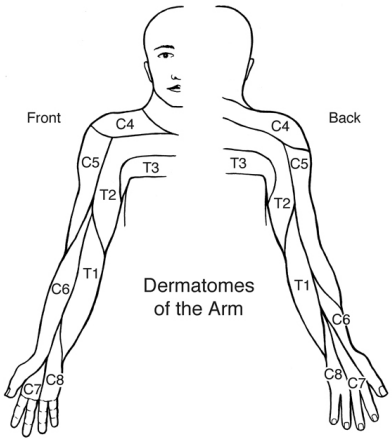
Pain Characteristics

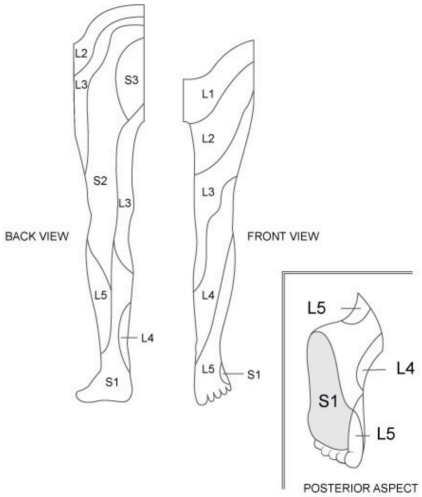
Please describe pain as indicated below:

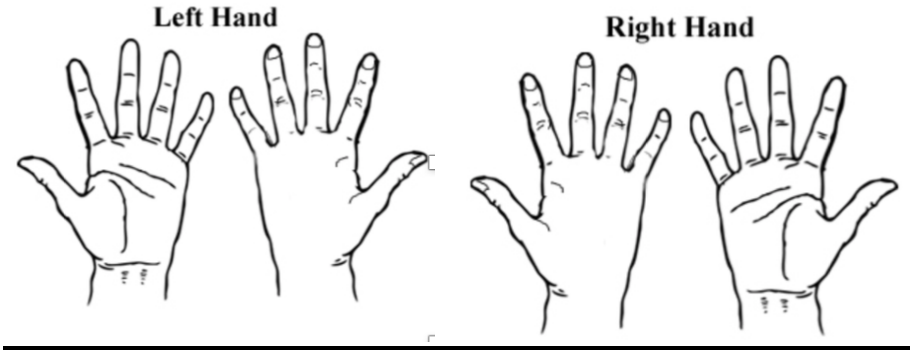
Pain	Aching	Stabbing/Sharp	Burning	Numbness and Tingling
XXX	AAA	SSS	BBB	TTT

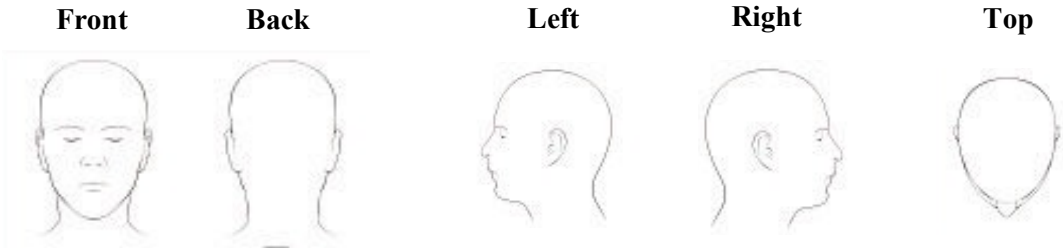


Upper Extremities Lower Extremities









Body Part	**Type of Pain** (i.e. dull, deep, sharp, aching, stabbing, burning, radiating)	**Severity of Pain** 0=No Pain 1=Mild Pain 2=Moderate Pain 3=Severe Pain	**Frequency of Pain** N=Never R=Rare O=Occasional I=Intermittent C=Constant	**Aggravated By** (i.e. pushing, pulling, sitting, standing, walking, typing, sleeping, driving, dressing, personal hygiene, sleeping)	**Relieved By** (i.e. pushing, pulling, sitting, standing, rest, massage, medication)	**Caused by Injury** Y/N
Head						
Neck						
Right Shoulder						
Left Shoulder						
Right Upper Arm						
Left Upper Arm						
Right Elbow						
Left Elbow						

Body Part	**Type of Pain** (i.e. dull, deep, sharp, aching, stabbing, burning, radiating)	**Severity of Pain** 0=No Pain 1=Mild Pain 2=Moderate Pain 3=Severe Pain	**Frequency of Pain** N=Never R=Rare O=Occasional I=Intermittent C=Constant	**Aggravated By** (i.e. pushing, pulling, sitting, standing, walking, typing, sleeping, driving, dressing, personal hygiene, sleeping)	**Relieved By** (i.e. pushing, pulling, sitting, standing, rest, massage, medication)	**Caused by Injury** Y/N
Right Forearm						
Left Forearm						
Right Wrist						
Left Wrist						
Left Hand/ Fingers						
Right Hand/ Fingers						
Upper and Mid Back						
Low Back						
Coccyx						
Pelvis						
Right Hip						
Left Hip						
Right Thigh						
Left Thigh						
Right Knee						

Body Part	**Type of Pain** (i.e. dull, deep, sharp, aching, stabbing, burning, radiating)	**Severity of Pain** 0=No Pain 1=Mild Pain 2=Moderate Pain 3=Severe Pain	**Frequency of Pain** N=Never R=Rare O=Occasional I=Intermittent C=Constant	**Aggravated By** (i.e. pushing, pulling, sitting, standing, walking, typing, sleeping, driving, dressing, personal hygiene, sleeping)	**Relieved By** (i.e. pushing, pulling, sitting, standing, rest, massage, medication)	**Caused by Injury** Y/N
Left Knee						
Right Calf						
Left Calf						
Right Ankle						
Left Ankle						
Right Foot						
Left Foot						

Sleep Characteristics

Sleep Criteria	**Unit**	**Measurements**
Sleep duration		Hours
Total painful interruptions		Episodes
Minutes to falling asleep		Minutes
Minutes to getting out of bed		Minutes
Early morning fatigue (0=absent; 1=mild; 2=moderate; 3=severe)		Fatigue
Late afternoon fatigue (0=absent; 1=mild; 2=moderate; 3=severe)		Fatigue

Afternoon Sleepiness Risks

Please rate risk of feeling tired while:

Afternoon Sleepiness	**Risk (0=Absent; 1=Mild; 2=Moderate; 3=Severe)**
Reading quietly	
Watching TV quietly	
Sitting quietly	
Lying down quietly	
Chatting quietly	
Digesting meal	
Traveling quietly	
Sitting quietly in vehicle	

Pain (Self-report of Severity)

Please circle one of the following numbers that describes your pain:

A. Rate how severe your pain is **right now**, at this moment.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Most severe pain you can imagine

B. Rate how severe your pain is **at its worst**.

0 1 2 3 4 5 6 7 8 9 10
None — Excruciating

C. Rate how severe your pain is **on the average***)*

0 1 2 3 4 5 6 7 8 9 10
None — Excruciating

D. Rate how much your pain is **aggravated by activity**.

0 1 2 3 4 5 6 7 8 9 10
Activity does not aggravate pain — Excruciating following any activity

E. Rate how frequently you experience pain.

0 1 2 3 4 5 6 7 8 9 10
Rarely — All of the time

Activity Limitation of Interference

A. How much does your pain interfere with your ability to **walk 1 block?**

0 1 2 3 4 5 6 7 8 9 10
Does not restrict ability to walk — Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** such as a bag of groceries?

0 1 2 3 4 5 6 7 8 9 10
Doesn't prevent from lifting 10 pounds — Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for ½ hour?** *(Please circle)*

0 1 2 3 4 5 6 7 8 9 10
Doesn't restrict ability to sit ½ hour — Impossible to sit for ½ hour

D. How much does you pain interfere with your ability to **stand for ½ hour?**

0 1 2 3 4 5 6 7 8 9 10
Doesn't restrict ability to stand ½ hour — Impossible to stand at all

E. How much does your pain interfere with your ability to **get enough sleep?**

0 1 2 3 4 5 6 7 8 9 10
Doesn't prevent me from sleeping — Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities?**

0 1 2 3 4 5 6 7 8 9 10
Doesn't interfere — Completely interferes

G. How much does your pain interfere with your ability to **travel up to 1 hour by car?**

0 1 2 3 4 5 6 7 8 9 10
Doesn't interfere — Completely unable to travel

H. In general, how much does your pain interfere with your **daily activities?**

0 1 2 3 4 5 6 7 8 9 10
Doesn't interfere — Completely interferes

I. How much do you **limit your activities to prevent your pain from getting worse?**

0 1 2 3 4 5 6 7 8 9 10
Doesn't limit activities — Completely limits activities

J. How much does your pain interfere with your **relationships with your family/ partner/ significant other?**

0 1 2 3 4 5 6 7 8 9 10
Doesn't interfere — Completely interferes

K. How much does your pain interfere with your ability to do **jobs around the house?**

0 1 2 3 4 5 6 7 8 9 10
Doesn't interfere — Completely unable to do any jobs around the house

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else?**

0 1 2 3 4 5 6 7 8 9 10
Doesn't interfere — Pain makes it impossible to shower or bathe without help

M. How much does your pain interfere with your ability to **write or type?**

0 1 2 3 4 5 6 7 8 9 10
Doesn't interfere — Completely unable to write or type

N. How much does your pain interfere with your ability to **dress yourself?** *(Please circle)*

0	1	2	3	4	5	6	7	8	9	10
Doesn't interfere										Completely interferes

O. How much does your pain interfere with your ability to **engage in sexual activities?**

0	1	2	3	4	5	6	7	8	9	10
Doesn't interfere										Completely limits activities

P. How much does your pain interfere with your ability to **concentrate?**

0	1	2	3	4	5	6	7	8	9	10
Doesn't interfere										All the time

Individual's Report of Effect of Pain on Mood

A. Rate your **overall mood** during the past week *(Please circle)*

0	1	2	3	4	5	6	7	8	9	10
Extremely high/good										Extremely low/bad

B. During the past week, how **anxious or worried** have you been because of your pain?

0	1	2	3	4	5	6	7	8	9	10
Not at all anxious/worried										Extremely anxious/worried

C. During the past week, how **depressed** have you been because of your pain?

0	1	2	3	4	5	6	7	8	9	10
Not at all										Extremely depressed

D. During the past week, how **irritable** have you been because of your pain?

0	1	2	3	4	5	6	7	8	9	10
Not at all										Extremely irritable

E. In general, how anxious/worried are you about performing activities because they **might make your pain/symptoms worse?**

0	1	2	3	4	5	6	7	8	9	10
Not at all										Extremely

Pain Impact on Mental Health (PHQ-9)

Over the last 2 weeks, I have been bothered by any of the following problems due to pain or other causes?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in activities	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep	0	1	2	3
4 Feeling tired or lacking energy	0	1	2	3
5. Abnormal change in appetite	0	1	2	3
6. Feeling upset with myself, sense of failure	0	1	2	3
7. Trouble concentrating for simple activities	0	1	2	3
8. Thinking or speaking slowly	0	1	2	3
9. Thoughts of death or self-harm	0	1	2	3
Total of above scores				
Do you think that the chronic pain has contributed to these issues. Yes, No, Maybe				

Injury Treatment History

Name of current treating doctor for your injury or illness? _____

Who has provided treatment for this injury/illness?	Dates of Treatments From / To	Type of Treatment	Treatment: (Ongoing or Released) ?

List **ALL** MEDICATIONS that you are presently taking or have previously taken (prescription and over-the-counter):

Medication	Dosage	How Often?	Date Begun	Currently Taken? Yes or No

Medical History

List ALL Prior Injuries:

Date	Body Parts	Type of Injury (Vehicle, Fall, Cumulative), Childhood)	Residual Disability

List ALL Conditions Not Arising from the Injury

Body Parts	Date of Onset	Treatment	Name of Treating Physician

List ALL Surgeries

Body Part	Date of Surgery	Type of Surgery	Name of Surgeon

Employment

Prior History of Employment

List **ALL** employers **PRIOR** to your injury:

Name of Employer	Occupation	Job Title	Date Begun	Date Ended

Employment at Time of Injury

Employer at time of Injury: _____ Date of Hire _____

Occupation at time of Injury: Job Title _____

Are you currently working with this employer? ❑ Yes ❑ No

If "No," what was your last day working? _____

Current Employment

Current Employer: _____ Date of Hire _____

Current Occupation: _____ Job Title _____

Describe your current income (check all that apply):

❑ No Income ❑ Temporary Disability Benefits ❑ EDD

How often are you working? ❑ Full Time ❑ Part Time ❑ Not Working

If "Part Time," how often? _____ days per week

_____ hours per week

_____ hours per day

What kind of duties are you working? ❑ Regular ❑ Modified ❑ Not Working

If working **modified duties**, please specify restrictions: *Example: No lifting more than 20 lbs*

Employment Following Injury

Where have you worked **SINCE** your injury or illness?

Name of Employer	Occupation	Job Title	Date Begun	Date Ended

Current Work & Functional Capacity Estimation Summary

Please check the appropriate box. Please complete based on ***your estimate of your capacity at the current time.*** *This is a measure of how long you are able to tolerate these activities, not how long your occupation requires you to do them.*

Frequency	**Never**	**Rare**	**Infrequent**	**Frequent**	**Constant**
Hours Per Day	**0 Hrs**	**1-2 Hrs**	**2-4 Hrs**	**4-6 Hrs**	**6-8 Hrs**
Repetitive Neck Motions					
Static Neck Posturing					
Bending/Twisting (Waist)					
Squatting & Kneeling					
Sitting					
Standing					
Walking					
Climbing Stairs					
Walking Over Uneven Ground					
Working At Heights					
Working Around Moving Machinery					
Repetitive Use of Upper Extremity (Right)					
Repetitive Use of Upper Extremity (Left)					
Grasping/Gripping (Left Hand)					
Forceful Use of Upper Extremity (Right)					
Forceful Use of Upper Extremity (Left)					
Fine Manipulation (Right Hand)					
Fine Manipulation (Left Hand)					
Reaching (At Shoulder Level)					
Reaching (Above Shoulder Level)					
Pushing & Pulling (Right) – **In Pounds**					
Pushing & Pulling (Left) **– In Pounds**					

Lift and Carry Limitations at this time				
Pounds	**Never**	**Occasional up to 3 hours**	**Frequent 3-6 hours**	**Constant 6-8 hours**
0-5				
6-10				
11-15				
16-20				
21-30				
31-40				
41-50				
50-75				
76+				

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Description of Employee's Job Duties when Hired

The following is an excerpt from the DWC California State Form 10133.33. Please fill out the form based on the ***job duties you were required to perform when you were hired.*** *This is to determine your physical capacities prior to your injury.*

Job Title: _____ Hrs. Worked Per Day _____ Hrs. Worked Per Week _____

Description of Job Responsibilities: (Describe All Job Duties):

Please check one: Regular Duty ☐ Modified Duty ☐ Alternative Work ☐

1. Check the frequency of activity required of the employee to perform the job.

ACTIVITY (Hours per day)	NEVER 0 HOURS	OCCASIONALLY UP TO 3 HOURS	FREQUENTLY 3-6 HOURS	CONSTANTLY 6-8+ hours
Sitting	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Bending (neck)	☐	☐	☐	☐
Bending (waist)	☐	☐	☐	☐
Squatting	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Twisting (neck)	☐	☐	☐	☐
Twisting (waist)	☐	☐	☐	☐
Hand Use: Dominant hand: ◯ Right ◯ Left	☐	☐	☐	☐
Is repetitive use of hand	☐	☐	☐	☐
Simple Grasping (right hand)	☐	☐	☐	☐
Simple Grasping (left hand)	☐	☐	☐	☐
Power Grasping (right hand)	☐	☐	☐	☐
Power Grasping left hand)	☐	☐	☐	☐
Fine Manipulation (right hand)	☐	☐	☐	☐
Fine Manipulation (left hand)	☐	☐	☐	☐
Pushing & Pulling (right hand)	☐	☐	☐	☐
Pushing & Pulling (left hand)	☐	☐	☐	☐
Reaching (above shoulder level)	☐	☐	☐	☐
Reaching (below shoulder level)	☐	☐	☐	☐
Keyboarding with both hands	☐	☐	☐	☐

2. Please indicate the daily Lifting and Carrying requirements of the job: Indicate the height the object is lifted from floor, table or overhead location and the distance the object is carried.

	LIFTING					CARRYING				
	Never 0 hrs	Occasionally up to 3 hrs	Frequently 3-6 hrs	Constantly 6-8+	Height	Never 0 hrs	Occasionally up to 3 hrs	Frequently 3-6 hrs	Constantly 6-8+	Distance
0 - 10 lbs	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
11 - 25 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
26 - 50 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
51 - 75 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
76 - 100 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
100+ lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____

Describe the heaviest item required to carry and the distance to be carried:

3. Please indicate if your job requires:

	YES	NO	(IF YES, PLEASE BRIEFLY DESCRIBE)
a. Driving cars, trucks, forklifts and other equipment?	○	○	_____
b. Working around equipment and machinery?	○	○	_____
c. Walking on uneven ground?	○	○	_____
d. Exposure to excessive noise?	○	○	_____
e. Exposure to extremes in temperature, humidity or wetness?	○	○	_____
f. Exposure to dust, gas, fumes, or chemicals?	○	○	_____
g. Working at heights?	○	○	_____
h. Operation of foot controls or repetitive foot movement?	○	○	_____
i. Use of special visual or auditory protective equipment?	○	○	_____
j. Working with bio-hazards such as: blood borne pathogens, sewage, hospital waste, etc.?	○	○	_____

Employee Comments