**MD PAIN SPECIALISTS**
**Mailing Address:**
7040 Avenida Encinas #104-248
Carlsbad, CA 92011
PH: 760.734.1800 FX: 760.734.1888

**Appointment Time/Date:** 5pm Apr. 23.11 **Doctor:** Dr. Shaw **Ref. By** Ronald Stein
**INTERPRETER:** YES (NO) NA **Ph:** NA **Fax:** NA

EXAM/TX CONSULT/TX WC CONSULT PI QME AME IME AOE/COE

**PATIENT NAME:** Tiffany Anderson **DOB:** 8-22-1970 **SSN:**
**ADDRESS:** 2 N Avena Avenue
**HOME PH** 209-329-9523 **WORK PH:** 209-982-467 **OTHER**
**SEX:** F **MARITAL STATUS:** Single **DRIVERS LIC:**
**EMERGENCY CONTACT:** Robert Blewett **RELATIONSHIP:** boyfriend
**ADDRESS:** 20800 Valley Green Dr. #477 **PH:** 415-516-5258
Cupertino CA
**EMPLOYER (@TIME OF INJURY):** S. J. County Mosquito & Vector Control
**ADDRESS:** 7759 S. Airport Way **OCCUPATION:** pesticide applicator

**AREA OF BODY PART(S) INJURED:** right knee
**XRAYS + DATES (pertaining to today's visit):**

**WORKERS COMPENSATION INSURANCE:**
**NAME** AIMS Insurance **ADJUSTER:** Mackenzie Dawson
**ADDRESS:** P.O. Box 269120 **PH:** 916-563-1900 ext 242
**NCM:**
**PH** **FX:** 916-563-1919 **PH:**
**DATE OF INJURY:** 6-19-2008 **CLM#:** VE0700184
**WCAB** ADJ7004221; ADJ7004227
ADJ7010682

**ATTORNEY INFORMATION:** **APPLICANT/DEFENSE**
**NAME:** **PH:**
**ADDRESS:**
**CONTACT PERSON:** **FX:**

**REFERRING PHYSICIAN:**
**NAME:** **PH:**
**ADDRESS:**

**CONTACT PERSON:** **FX:**

Tiffany Anderson

4-23-11



# Appendix A

## Questions Concerning Activities of Daily Living (ADL)

**1. How well can you perform personal self care activities including washing, dressing, using the bathroom, etc?**

- [x] I can look after myself normally without extra discomfort
- [ ] I can look after myself normally with extra discomfort
- [ ] Self care activities are uncomfortable and done slowly
- [ ] I manage most of my personal self care with some help
- [ ] I need a lot of help daily in most aspects of my self care
- [ ] I cannot perform self care activities

**2. How well can you lift and carry?**

- [x] I can lift and carry heavy objects without extra discomfort
- [ ] I can lift and carry heavy objects but I get extra discomfort
- [ ] I can lift and carry heavy objects
- [ ] I can only lift and carry light to medium objects
- [ ] I can only lift very light objects
- [ ] I cannot lift or carry anything at all

**3. How well can you walk (you may check more than one box)?**

- [x] There is no change from before my injury
- [ ] Symptoms prevents me from walking more than 1 mile
- [ ] Symptoms prevents me from walking more than 1/2 mile
- [ ] Symptoms prevents me from walking more than 1/4 mile
- [ ] I walk only short distances
- [ ] I use a cane, crutches or walker
- [ ] I am limited to use of a wheelchair

**4. What is the most strenuous level of activity that you can do for at least 2 minutes?**

- [x] Very heavy activity
- [ ] Heavy activity
- [ ] Moderate activity
- [ ] Light activity
- [ ] Very light activity
- [ ] Extremely light to no activity

**5. How well can you climb one flight of stairs?**

- [x] No difficulty (and you can easily perform the activity)
- [ ] Some difficulty (but you can still perform the activity)
- [ ] A lot of difficulty (but you can still perform the activity)
- [ ] Cannot climb one flight of stairs

**6. How well can you sit for a period of time (even with some pain or discomfort) before you absolutely have to stand, walk or lay down?**

- [ ] I can sit without any time limitations
- [ ] I can only sit between 1 hour to 2 hours at a time
- [x] I can only sit between 30 and 60 minutes at a time
- [ ] I can only sit between 15 and 30 minutes at a time
- [ ] I can only sit for less than 15 minutes at a time
- [ ] I can not sit at all

**7. How well can you stand or walk for a period of time (even with some pain or discomfort) before you absolutely have to sit or lay down?**

- [ ] I can stand/walk without any time limitations
- [ ] I can only stand/walk between 1 hour to 2 hours at a time
- [ ] I can only stand/walk between 30 and 60 minutes at a time
- [x] I can only stand/walk between 15 and 30 minutes at a time
- [ ] I can only stand/walk for less than 15 minutes at a time
- [ ] I can not stand or walk at all

**8. How well can you reach and grasp something off a shelf at chest level?**

- [x] No difficulty (and you can easily perform the activity)
- [ ] Some difficulty (but you can still perform the activity)
- [ ] A lot of difficulty (but you can still do the activity)
- [ ] Unable (you cannot do this activity)

**9. How well can you reach and grasp something off a shelf overhead?**

- [x] No difficulty (and you can easily perform the activity)
- [ ] Some difficulty (but you can still perform the activity)
- [ ] A lot of difficulty (but you can still do the activity)
- [ ] Unable (you cannot do this activity)

**10. How well can you push or pull (even with some pain or discomfort)?**

- [ ] I can push or pull very heavy objects
- [x] I can push or pull heavy objects
- [ ] I can push or pull light objects
- [ ] I can push or pull very light objects
- [ ] I can not push or pull anything

**11. Do you have any difficulty with gripping, grasping, holding and manipulating objects with your hands?**

- [x] No difficulty (and you can easily perform the activity)
- [ ] Some difficulty (but you can still perform the activity)
- [ ] A lot of difficulty (but you can still do the activity)
- [ ] Unable (you cannot do this activity)

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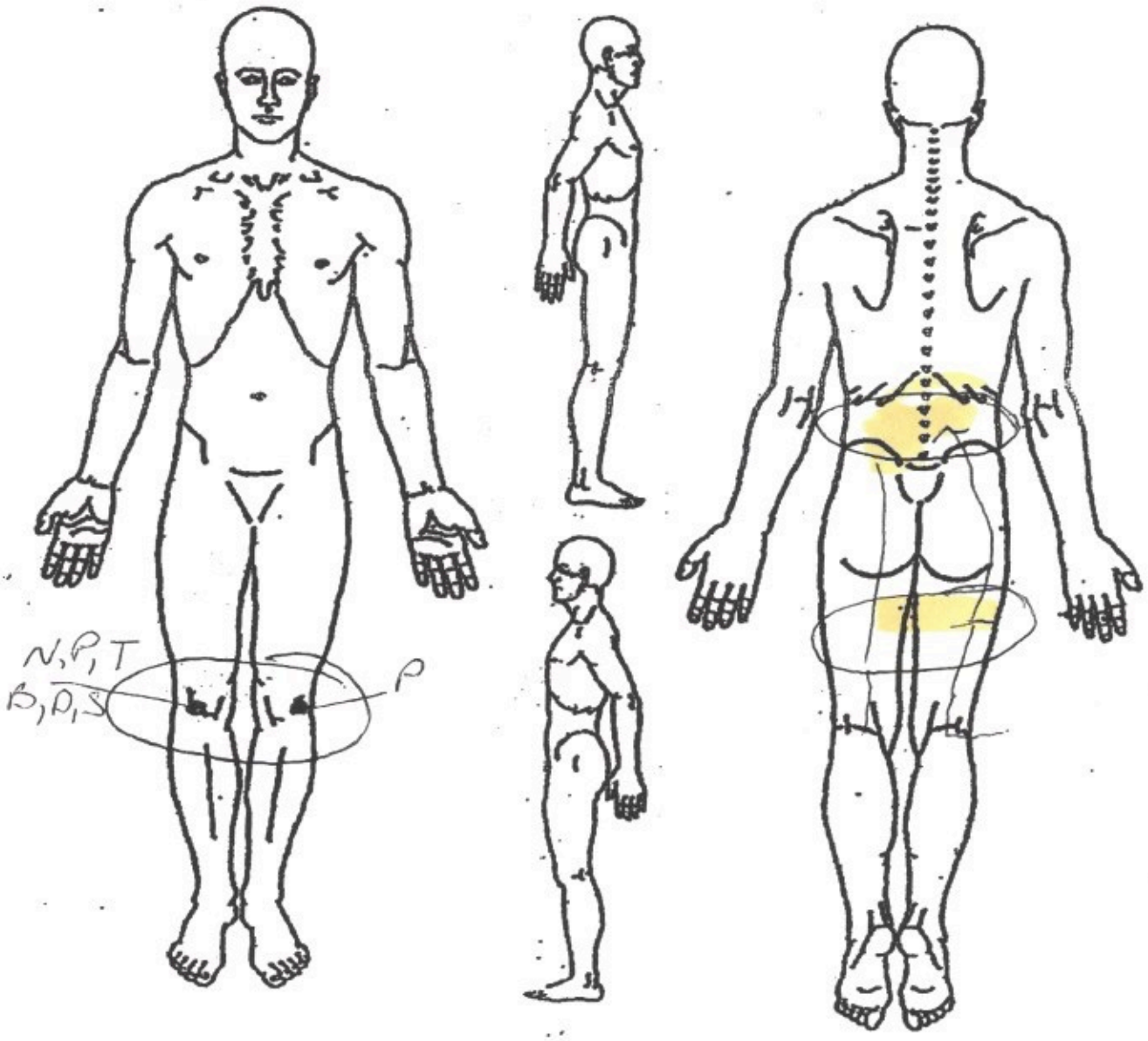
# RANSFORD PAIN DIAGRAM

On the drawings below, please indicate where you are experiencing pain by drawing in the letter abbreviatio on the diagrams that most accurately reflect the type of discomfort that you have been experiencing.

Numbness = N
Sharp Pain = P

Tingling = T
Burning = B

Dull Pain = D
Stiffness = S



Tiffany Anderson

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 | | | X | |
| Walking | | | | X |
| Standing | | X | | |
| Bending (neck) | | X | | |
| Bending (waist) | | X | | |
| Squatting | | X | | |
| Climbing | | X | | |
| Kneeling | | X | | |
| Crawling | | X | | |
| Twisting | | X | | |
| Hand use: Dominant Hand | | X | | |
| Repititive Hand Use Required? | | X | | |
| Simple Grasping (right hand) | | X | | |
| Simple Grasping (left hand) | | X | | |
| Power Grasping (right hand) | | X | | |
| Power Grasping (left hand) | | X | | |
| Fine Manipulation (right hand) | | X | | |
| Fine Manipulation (left hand) | | X | | |
| Pushing-Pulling (right hand) | | X | | |
| Pushing-Pulling (left hand) | | X | | |
| Reaching Above Shoulder (right hand) | | X | | |
| Reaching Above Shoulder (left hand) | | X | | |
| Reaching Below Shoulder (right hand) | | X | | |
| Reaching Below Shoulder (left hand) | | X | | |

Patient's Signature 

Date: 4-23-11

# Oswestry Disability Questionnaire

Tiffany Anderson

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem.**

## Section 1: Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☒ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

## Section 2: Personal Care (eg. washing, dressing)

- ☒ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but can manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, wash with difficulty and stay in bed

## Section 3: Lifting

- ☒ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

## Section 4: Walking*

- ☒ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 2 kilometres
- ☐ Pain prevents me from walking more than 1 kilometre
- ☐ Pain prevents me from walking more than 500 metres
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

## Section 5: Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☒ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

## Section 6: Standing

- ☐ I can stand as long as I want without extra pain
- ☒ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

## Section 7: Sleeping

- ☒ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

## Section 8: Sex Life (if applicable)

- ☒ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

## Section 9: Social Life

- ☒ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

## Section 10: Travelling

- ☐ I can travel anywhere without pain
- ☒ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

Tiffany Anderson

## Activities of Daily Living

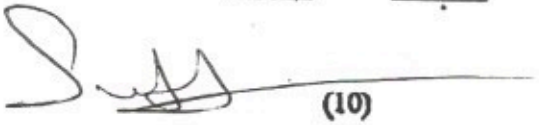
| Please indicate your difficulty level if any, at this time. | Without Difficulty 0 | With Some Difficulty 1 | With Much Difficulty 2 | Unable To Do 3 |
|---|---|---|---|---|
| **A. Self care-are you able to:** | | | | |
| Dress yourself including shoes | 0 | | | |
| Comb your hair | 0 | | | |
| Wash and dry yourself | 0 | | | |
| Take a bath | 0 | | | |
| Get on and off the toilet | 0 | | | |
| Brush your teeth | 0 | | | |
| Cut your food | 0 | | | |
| Lift a full cup/glass to your mouth | 0 | | | |
| Open a new milk carton | 0 | | | |
| Make a meal | 0 | | | |
| **B. Communication-are you able to:** | | | | |
| Write a note | 0 | | | |
| Type a message on the computer | 0 | | | |
| See a television screen | 0 | | | |
| Use a telephone (hearing) | 0 | | | |
| Speak clearly | 0 | | | |
| **C. Sensory-are you able to:** | | | | |
| Feel what you touch | 0 | | | |
| Smell the food you eat | 0 | | | |
| Taste the food you eat | 0 | | | |

Tiffany Anderson

(Continued)

| | Without Difficulty 0 | With Some Difficulty 1 | With Much Difficulty 2 | Unable To Do 3 |
|---|---|---|---|---|
| **D. Hand activities-are you able to:** | | | | |
| Open car doors | 0 | | | |
| Open previously opened jars | 0 | | | |
| Turn faucets on and off | 0 | | | |
| **E. Physical activity-are you able to:** | | | | |
| Work out doors on flat ground | | 1 | | |
| Work out doors on uneven ground | | 1 | | |
| Climb up five flights of steps | 0 | | | |
| Stand | | 1 | | |
| Walk | 0 | | | |
| Sit | 0 | | | |
| Recline | 0 | | | |
| Rise from a chair | 0 | | | |
| Run errands | 0 | | | |
| Light house work | 0 | | | |
| **F. Sexual difficulty-are you able to:** | | | | |
| Lubrication | 0 | | | |
| Erection | 0 | | | |
| Orgasm | 0 | | | |
| Ejaculation | 0 | | | |
| **G. Travel-are you able to:** | | | | |
| Riding | | 1 | | |
| Driving | | 1 | | |
| Flying | 0 | | | |
| Shop | 0 | | | |
| Get in and out of a car | 0 | | | |
| **H. Sleep/personal-are you able to:** | | | | |
| Sleep-restful | 0 | | | |
| Sleep-pattern | 0 | | | |

**Patient's Signature**



Revised 3-19-07

*Figure 1c. Screener and Opioid Assessment for Patients with Pain (SOAPP)*

The 14-question version is provided in this Guideline.

Name: Tiffany Anderson Date: 4-23-11

**The following are some questions given to all patients at the (name of clinic or practice) who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.**

**Please answer the questions below using the following scale:**

**0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very often**

| | | | | | |
|---|---|---|---|---|---|
| 1. How often do you have mood swings?* | 0 | 1 | (2) | 3 | 4 |
| 2. How often do you smoke a cigarette within an hour after you wake up?* | (0) | 1 | 2 | 3 | 4 |
| 3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | (4) |
| 4. How often have any of your close friends had a problem with alcohol or drugs? | 0 | (1) | 2 | 3 | 4 |
| 5. How often have others suggested that you have a drug or alcohol problem? | (0) | 1 | 2 | 3 | 4 |
| 6. How often have you attended an AA or NA meeting? | (0) | 1 | 2 | 3 | 4 |
| 7. How often have you taken medication other than the way that it was prescribed?* | (0) | 1 | 2 | 3 | 4 |
| 8. How often have you been treated for an alcohol or drug problem? | (0) | 1 | 2 | 3 | 4 |
| 9. How often have your medications been lost or stolen? | (0) | 1 | 2 | 3 | 4 |
| 10. How often have others expressed concern over your use of medication? | (0) | 1 | 2 | 3 | 4 |
| 11. How often have you felt a craving for medication? | (0) | 1 | 2 | 3 | 4 |
| 12. How often have you been asked to give a urine screen for substance abuse? | (0) | 1 | 2 | 3 | 4 |
| 13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?* | (0) | 1 | 2 | 3 | 4 |
| 14. How often, in your lifetime, have you had legal problems or been arrested?* | (0) | 1 | 2 | 3 | 4 |

*Please include any additional information you wish about the above answers. Thank you.*

*Item is included in the 5-item SOAPP Version 1.0-SF.

The score is the sum of ratings for all of the questions. A score of 7 or higher on the SOAPP Version 1.0-14Q or of 4 or higher on SOAPP Version1.0-SF is considered positive (i.e., detects a patient at risk for developing problems when placed on long-term opioid therapy).

Reprinted from *Pain*, 112, Butler SF, Budman SH, Fernandez K, et al, Validation of a screener and opioid assessment measure for patients with chronic pain, 65-75, Copyright (2004), with permission from Elsevier.

Patient's Name: Tiffany Kay Anderson

Date: April 23, 2011

| ADDRESS TO: (referred by) | |
|---|---|
| | |
| | |
| | |
| Tel: | |
| Fax: | |

| | |
|---|---|
| PATIENT: | Tiffany Anderson |
| EMPLOYER: | San Joaquin County Mosquito & Vector Control District |
| DATE OF INJURY: | 6-19-2008, 3-26-2009, 7-2-2009 |
| CLAIM#: | VE0700184 |
| EXAMINATION DATE: | |

☐ **NEUROSURGICAL CONSULTATION**

☐ **PRIMARY TREATING INITIAL NEUROSURGICAL EVALUATION**

☐ **ORTHOPEDIC INITIAL EVALUATION**

☐ **PRIMARY TREATING INITIAL ORTHOPEDIC EVALUATION**

☐ **PRIMARY TREATING INITIAL CHIROPRACTIC EVALUATION**

☐ **PAIN MANAGEMENT CONSULTATION**

**CC:**

| | | | |
|---|---|---|---|
| Name: | | Name: | |
| Address: | | Address: | |
| | | | |
| Tel: | | Tel: | |
| Fax: | | Fax: | |

Patient's Name:

1. How old are you? 40 Circle one: (Right Handed) or Left Handed Male or (Female)

3. In today's interview and examination will you be needing the assistance of an interpreter?

Yes (No) If yes what is the interpreter's Name: NA

And what is their company's Name: _____

**EMPLOYMENT HISTORY:**

1. What is your employer's name: San Joaquin County Mosquito & Vector Control

2. When did you start working for this company? 4-2004

**CURRENT EMPLOYER JOB DUTIES:**

1. What is your occupation? pesticide applicator/Tech I

2. According to you which of the following activities were required by your position?

☒ to sit ☒ stand ☒ walk ☒ bend ☒ push ☒ pull ☒ reach ☒ work above shoulder level,

☒ Constant usage of the upper ☒ extremities/lower extremities ☒ kneel ☒ climb ☒ lift

☒ The maximum amount lifted was up to 50 pounds.

**CURRENT WORK STATUS:**

1-Are you employed by this company at this time?

☒ Yes / ☐ No

2-Are you currently working.

☒ Yes / ☐ No If not when was the last day you worked? N/A

**HISTORY OF INJURY:**

1-How did you injured yourself (please give details)

Walking through eroded pasture land and climbing over fences for access. Although this information has not been of interest thus far; I was under tremendous stress by employer and was being retaliated for filing a sexual harassment complaint July 2007.

2. What body parts did you suffer injuries to from this accident?

☐ Head ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Lower Back

☐ Shoulder R / L ☐ Arm R / L ☐ Elbow R / L ☐ Wrist R / L ☐ Hand R / L

☐ Leg R / L ☒ Knee (R) / L ☐ Ankle R / L ☐ Foot ☒ Other my left knee and hip is starting to be affected to compensate for my injury. I also have emotional issues tied to this injury.

Patient's Name:

3-Who did you report the injury to after it happened?
☒ Employer ☒ Supervisor ☒ Other Complaints to government agencies

4-Did you continue to work your shift?
☒ Yes / ☐ No if no, did you go home? ☐ Yes / ☐ No

5-Where did you go after the injury?
☐ Home ☐ Hospital ☒ Company's Clinic ☐ other: _____

6-Were you send to the doctor?
☒ Yes / ☐ No If yes, were you sent ☒ the same day ☐ the next day ☐ other: _____

7-What doctors did you see?
☐ Chiropractor ☐ Orthopedic ☒ General Practitioner ☒ other: Surgeon

8-What kind of treatment was provided?
☒ Medications ☐ Brace ☐ Injections ☒ Therapy surgery

9-What kind of therapy did you receive and for how long?

☒ Physical Therapy # of sessions: many

☐ Chiropractic Therapy # of sessions: _____

☐ Acupuncture Therapy # of sessions: _____

10-Did you have any diagnostic studies performed?
☐ Yes / ☐ No If yes, what type of study?
☒ X-Rays, ☒ MRI's, ☐ CT Scans, ☐ EMG/NCV Test, or other: _____
When? _____ see medical file
Where? _____
What body part? right Knee

**SUBSEQUENT EMPLOYMENT HISTORY:**

1-Are you currently working?
☒ Yes / ☐ No If yes, are you working for the same company?
☒ Yes / ☐ No
If no, what is the name of the company you are currently working for, what is your job title, date of employment and briefly describe the job and physical duties?

_____
_____
_____

2-Are you working under light duty and with restrictions?
☒ Yes / ☒ No If yes what are you restricted from:
☐ Bending ☐ Stooping ☐ Squatting ☐ Twisting ☐ Turning
☐ Pushing ☐ Pulling ☐ Prolonged standing, walking, sitting.
☐ Lifting more than _____ pounds

I am now legaly partialy disabled my employer excepted my disibility but their expectations are the same as prior to my injury without the fear

Patient's Name: Tiffany Anderson

3-If you are currently not working when was the last day you worked? NA

4-If you are currently not working are you on disability? NA
☐ Yes / ☐ No If yes, what doctor placed you on disability and for how long? _____

5- Are you receiving disability benefits? NA
☐ Yes / ☐ No If yes, is it from the ☐ EDD (State Disability)
☐ Workers compensation insurance carrier?

**PRESENT COMPLAINTS:**

1-Are your current complaints ☒ constants, ☐ intermittent, ☐ moderate, ☐ severe, or ☐ do they come and go?

2-Where do you have pain?
☐ Head ☐ Neck ☐ Upper Back ☒ Mid Back ☒ Lower Back ☒ Shoulder R / L
☐ Arm R / L ☐ Elbow R / L ☐ Wrist R / L ☐ Hand R / L ☐ Leg R / L
☒ Knee (R) / L ☐ Ankle R / L ☐ Foot R / L ☐ Other:

3-On a scale 1-10 how do you rate your pain? 3-7

4-Does your pain radiate to your arms? *(Please choose which apply)*
☐ Yes / ☒ No If yes, does it radiate to which arm ☐ L / ☐ R or ☐ both.

5-Does your pain travel to your legs? *(Please choose which apply)*
☒ Yes / ☐ No If yes, does it radiate to which leg ☐ L / ☐ R or ☒ both

6-Do you have any tingling? right knee
☒ Yes / ☐ No If yes, where do you have it ☐ Arms ☐ Legs ☐ Hands or ☐ Feet

7-Do you have any numbness? *(Please choose which apply)*
☐ Yes / ☒ No If yes, where do you have it ☐ Arms ☐ Legs ☐ Hands or ☐ Feet

8-Do you have any weakness? *(Please choose which apply)* right knee
☒ Yes / ☐ No If yes, where do you have it ☐ Arms ☒ Legs ☐ Hands or ☐ Feet

9-Do you have any complaints of bowel or bladder problems? *(Please choose which apply)*
☐ Yes / ☒ No

10-Has your pain improved?
☐ Yes / ☒ No

If yes, it has ceased with which of the following? *(Please choose which apply)*
☒ Rest ☒ Medication ☐ Heat ☒ Ice ☒ Elevation ☐ Bracing
☒ Compression ☒ other: exercise

If not what has aggravates the pain? *(Please choose which apply)*

Patient's Name: Tiffany Andersan

☐ Bending ☒ Prolonged standing ☐ Prolonged sitting ☐ Reaching
☒ Prolonged walking ☐ Stooping ☐ squatting ☐ kneeling
☐ Coughing ☐ sneezing ☐ lifting ☐ carrying ☐ Bearing down

**PAST MEDICAL HISTORY:**

1-Have you had any previous problems with the current body parts injured?
☐ Yes / ☒ No If yes explain: _____

**2-Automobile Accidents:**
Have you had any prior motor vehicle accidents?
☐ Yes / ☒ No If yes explain: but I did incur being rear ended in my company vehicle and my employer did not send me to the Dr. December 17, 11

**3-Industrial Injuries:**
Have you had any prior industrial related injuries?
☐ Yes / ☒ No If yes explain: _____

**4-Non-Industrial Injuries:**
A-Have you had any prior non-industrial injuries?
☒ Yes / ☐ No If yes explain: Sprained ankle when I was in mid 20's.

B-Prior to the above industrial injury, were you in a good physical condition?
☒ Yes / ☐ No If yes explain: _____

**5-Allergies:**
Do you have any known allergies to medications?
☒ Yes / ☐ No If yes explain: to pollens & dusts not to foods or meds.

**PAST OR CURRENT MEDICAL ILLNESSES:**

**1-Medical:**
Do you suffer or have suffered any of the following: (diabetes mellitus, arthritis, lung disease, epilepsy, hypertension, collagen disease, cancer or other _____) ☐ Yes / ☒ No

**2-Current Medications:**
Are you currently taking any medications?
☒ Yes / ☐ No If yes explain: will discuss in person

**3-Surgeries:**
Have you had any surgeries?
☒ Yes / ☐ No If yes explain: 2

**4-Hospitalization:**
Have you ever been hospitalized for any treatment?
☒ Yes / ☐ No If yes explain: 2 births natural

**FAMILY AND SOCIAL HISTORY:**

1-What is your date of birth? 8-22-1970

2-Is your mother alive?
yes

Patient's Name: Tiffany Anderson

☒ Yes / ☐ No Any health problems? Migraines due to stress

3-Is your father alive?
☒ Yes / ☐ No Any health problems? NA

4-How many brothers do you have? 0

5-How many sisters do you have? 0

6-How many children do you have? 2

7-Is there a family history of:
☐ Cancer ☐ Heart disease ☐ Diabetes ☐ hypertension ☐ other: NA

8-Alcohol:
Do you drink alcohol?
☐ Yes / ☒ No
If yes, how often? ☐ Occasionally ☐ Socially ☐ Rarely ☐ Moderately

9-Tobacco:
Do you smoke?
☐ Yes / ☒ No
If yes, how often? ☐ Occasionally ☐ Socially ☐ Rarely ☐ Moderately

## Activities of Daily Living Assessment

**Please mark activities you have difficulty performing which were caused by this injury:**

**Difficulties with Self Care and Personal Hygiene Activities**
☐ Brushing teeth ☐ Putting on shoes ☐ Preparing meals ☐ Taking out trash ☐ Showering
☐ Making bed ☐ Eating ☐ Doing laundry ☐ Dressing your self ☐ Cleaning

**Difficulties with Physical Activities**
☒ Standing ☐ Walking ☐ Kneeling ☐ Twisting ☐ Leaning Back ☒ Sitting ☐ Stooping
☐ Reaching ☐ Squatting ☐ Bending forward ☒ Standing for long periods
☒ Sitting for long periods ☐ Walking for long periods ☐ Kneeling for long periods

**Difficulties with Functional Activities**
☐ Carrying ☐ Lifting ☐ Pushing ☐ Exercising ☐ Climbing stairs ☐ Pulling

**Difficulties with Social and Recreational Activities**
☒ Jogging ☐ Swimming ☐ Competitive Sports ☐ Golfing ☐ Dancing ☐ Hobbies

**Difficulties with Different Forms of Communication**
☒ Concentrating ☒ Hearing ☒ Listening ☐ Speaking ☐ Reading ☐ Writing ADD diagnose 1990

**Difficulties with the Senses**
☐ Seeing ☐ Hearing ☐ Sense of touch ☐ Sense of taste ☐ Sense of smel

**Difficulties with Hand Functions**
☐ Grasping ☐ Holding ☐ Pinching ☐ Percussive movements ☐ Sensory discrimination

Patient's Name: Tiffany Anderson

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

**AS A consequence of Your Injuries Have You Experience:**

1. Problems of Difficulty Sleeping? ☐Yes / ☐No
2. Experiencing Anxiety, Depression, Stress, Irritableness, financial & Job uncertainty ☒Yes / ☐No
3. Experienced Pain for more than two weeks? ☒Yes / ☐No
4. Experiencing Headaches or Dizziness? ☒Yes / ☐No
5. Experienced Weight Gain (Metabolic Disorder) ? ☐Yes / ☒No
6. Problems going to the bathroom/ loss of control? (Urination, Defecation, etc.) (Incontinence) ☐Yes / ☒No
7. Problems with Sexual Function? (Performance, Drive, Erection, Lubrication, etc.) ☐Yes / ☒No
8. Do you have any scarring on the skin from Your Industrial Injury? ☒Yes / ☐No Scar tissue inside Knee
9. Do have High Blood Pressure, Cardiovascular Problems, Strokes? ☐Yes / ☐No

If You Are Already Taking Medication FOR YOUR INJURY, Have You Experienced:

1. Loss of Concentration, memory (cognitive impairment)? ☐Yes / ☒No
2. Upset Stomach / Acid Reflux from medications? (Gastro Esophageal Impairment) ☐Yes / ☒No

Any other Problems? _____

**PHYSICAL EXAMINATION:**

How tall are you? 5 feet 4 inches
How much do you weight? 145 lbs.

**The above information is true and correct and to the best of my knowledge.**

_____ 4-23-11 _____

**Patient's Signature** **Date** **Interpreter's Name (if applicable)**

**Thank you for taking your time to fill out this questionnaire. Should you have any questions feel free to ask for assistance.**