10.8.09
Shaw

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This questionnaire refers to your chance of falling asleep, according to your usual way of life, for about the last week or two. Even if you have not done some of these things recently, try to estimate how they would have affected you during the last two weeks.

Use the following scale to choose the most appropriate number for each situation:
Scale:
0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of Dozing			
Sitting and reading	0	1	(2)	3
Watching TV	0	1	2	(3) noise is soothing
Sitting inactive in a public place (i.e.- in a theater or a meeting)	(0)	1	2	3 no trust
As a passenger in a car for an hour without a break	0	1	2	(3) with trust ←
Lying down to rest in the afternoon when circumstances permit	0	1	2	(3) no excuse
Sitting and talking to someone	(0)	1	2	3
Sitting quietly after a lunch without alcohol	0	1	(2)	3 high carbs you bet ←
In a car, while stopped for a few minutes in traffic	(0)	1		3
Total Epworth Score	13	[redacted]		strange test

Scoring:
7 or less = You have a normal amount of sleepiness
8 to 9 = You have a average amount of sleepiness
10 to 15 = You may be excessively sleepy depending on the situation and you may want to seek medic al attention
16 + up = You are excessively sleepy and should seek medical attention

Date 10-8-09 Signature [redacted]

Print Name Tiffany Kay Anderson

Medical Questionnaire .

Name Tiffany Kay Anderson

Date of Birth 8-22-1970

Date of Injury(ies) 6-19-08, 3-26-09, 7-1-09

How long did you work for your employer before the date of injury? 4 years

What was the last day you worked for your employer? 7-1-2009

Why was that your last date of work? John Stroh my manager, Eddie Luchessi the assistant and Brian Heine my supervisor met with me inquiring why I could not perform my job duties? I informed them I wanted mediation to discuss my

Are you presently working? Yes_____ No X If for a different employer, please list the name and the job duties → ?

Are you presently working for the same employer Yes X No X

Are you working with restrictions: Yes X No X

Describe your present working enviornment I am diagnosed modified work, my employer chooses not to accomodate there for I am currently not working.

If you are not working :

1. Are you being paid benefits? Yes X No_____ By Whom, Insurance or Edd?

If yes how much? 602.59 a week How Often? bi-weekly

2. Have you applied for Social Security and /or Medicare? Yes____ No X

If yes, Social Security Disability Income(SSDI) _____ or Supplemental Social Security____

New Injuries

Have you been involved in any new accidents ? Yes___ No X if so when?_____

Have you any new Injuries? Yes___ No X If yes, When?_____

We ask that you please notify your Primary Treating Doctor about any new injuries or any new symptoms that may arise out of your industrial injury. O.K

If you suffered a specific injury, do you believe that you might also have suffered a cumulative trauma, as a result of the kind of work you did for your employer over a period of time? Yes ☐ No

Please list all medication, dosage and doctor prescribing you took before the industrial injury.

The medication	Dosage	For what problem did you take the medication
1. Xanax was	1. daily as needed	anxiety is .25mg daily as needed
2. Norco 10-325	daily as needed	Chronic headaches now 4 10-325 daily
3. IB profin	800mg 3 times daily	headaches & menstrual as needed
4. maxalt MLT	10 mg as needed	migraines
5. Dr. tricel	opana & a few anti depressants	prior to 4-2009 for chronic headaches
6. Since no longer working on plan to reduce or eliminate all medications as of 4-2009		
7.		

8.
9.
10.
11.

Please list all medication, dosage and doctor prescribing you are presently taking for the industrial injury.(AMA Guides pg. 20,600,or interfere with ADL)

	The medication	Dosage	Who prescribed	How long have you been taking same
1.	Norco	7.5	Murata	1 every twelve hours
2.	along with IB profin already used for other			
3.	since 9-22-2008			
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				

Please list all medication, dosage and doctor prescribing you are presently taking for problems **other than the industrial injury, that you started to take after the industrial injury** .

	The medication	Who prescribed	For what problem	How long have you been taking same
1.				
2.				
3.	Please refer to pg 1			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

You might want to go to your pharmacy and ask if you can get both list of all of the medications you are taking for any purpose, and for the workers compensation injury and also the side effects from the medication's you are taking for the industrial injury. It will be important that this office has a copy of those records.

Also make sure that you take a copy of the list of side effects to your treating doctor and go over same with him or her. Under the workers compensation law, you are entitled to be treated and compensated for any lasting side effect of medication or side effects from the medication.

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List any side effects you actually have from the medication:

Medication:	Side Effect:	Body Part in which side effect occurred
1		
2		
3		
4		
5		
6		

Do you take any Non Steroid anti inflammatory medication ? Yes ☐ No ~~☑~~

Do you take any anti coagulant medication -such as Cumodin? Yes ☐ No ☒

Do you take any High Blood pressure medication? Yes ☐ No ☒

Did you take blood pressure medication before the industrial injury? Yes ☐ No ☒
If so Since the industrial injury are you taking MORE medication
for the high blood pressure? Yes ☐ No ☒

Did you take any Diabetes Medication prior to the industrial injury? Yes ☐ No ☒

Since the industrial injury do you take additional medication
for the Diabetes Yes ☐ No ☒

Do you take any Medication for Stomach problems? Yes ☐ No ☒

Do you take any medication for Sexual Problems Yes ☐ No ☒

Do You take any medication for Depression? Yes ☐ No ☒

Since your industrial have you had any diagnostic test Yes ☐ No ☐
If so, What test and for what purp ose? I do not Know what I had a blood panel 9-15-2008 to check for diabetes, liver damage from medication,
1.
2. lipid, glucose
3.
4. CBC, TSH, ALT, AST Serum
5.
6.

Since your injury have you had a complete physical? Yes ☐ No ☐
If so when was your last complete physical? I am seen regular by Physicians what is full physical?

If not, I would suggest you ask your treating doctor to send you for a complete physical to an internist and a cardiologist

In answering the following questions, please understand that we are speaking not only of problems that have resulted from the industrial accident , but also, problems that could have been a direct result, a secondary consequences, or could have been a condition or problem that was aggravated or lit up by the industrial injury. We are trying to find out what other parts of your body and or other problems you have, as a result of the industrial injury or a consequence of the industrial injury . Remember, due to the progressive nature of industrial problems to one part of the body is that you can end up with additional problems. You are entitled to be treated and compensated for those secondary consequences.

As a result of the injury what part(s) of your body were injured and/or what parts of your body are now giving you problems, which you and or your doctor believe are a result of the industrial injury.

Please answer yes regarding every part of your body that is now giving you problems.

As a result of the industrial injury are you having problems in any activity of daily living,such as
Self Care, Yes ☐ No ☒
Personal Hygiene, Yes ☐ No ☒
Communication, Yes ☐ No ☒
Physical Activity, Yes ☒ No ☐

Sensory Function,	Yes ☐ No ☒
Non Specified Hand Activities,	Yes ☐ No ☒
Travel	Yes ☐ No ☒
Sexuality Function ,	Yes ☐ No ☒
Sleep.	Yes ☐ No ☒

It will be important for you to discuss every problem with your treating doctor. We need to have a good medical record showing that you complained about every problem you believe is related to the industrial injury or a result of same. Are you having problems with any of the following parts of your body?

Neck AMA Chapter 15	Yes ☐ No ☒
Spine AMA Chapter 15	Yes ☐ No ☒
Upper extremities AMA Chapter 16	Yes ☐ No ☒
Shoulders AMA Chapter 16	Yes ☐ No ☒
Arms AMA Chapter 16	Yes ☐ No ☒
Elbows AMA Chapter 16	Yes ☐ No ☒
Hands AMA Chapter 16	Yes ☐ No ☒
Fingers AMA Chapter 16	Yes ☐ No ☒
Lower extremities AMA Chapter 17	Yes ☐ No ☒
Hips AMA Chapter 17	Yes ☒ No ☐
Knee(s) AMA Chapter 17	Yes ☒ No ☐
Ankles AMA Chapter 17	Yes ☐ No ☒
Feet AMA Chapter 17	Yes ☐ No ☒
Toes AMA Chapter 17	Yes ☐ No ☒
Heart AMA Chapter 3 & 4	Yes ☐ No ☒
Blood Pressure	Yes ☒ No ☐
Blood AMA Chapter 9	Yes ☐ No ☒
Veins AMA Chapter 4	Yes ☐ No ☒
Lungs AMA Chapter 5	Yes ☐ No ☒
Respiratory system AMA Chapter 5	Yes ☐ No ☒

Chest AMA Chapter 5	Yes ☐ No ☒
Stomach AMA Chapter 6	Yes ☐ No ☒
Digestive system AMA Chapter 6	Yes ☐ No ☒
Kidney AMA Chapter 7	Yes ☐ No ☒
Liver AMA Chapter 6	Yes ☐ No ☒
Skin AMA Chapter 8	Yes ☐ No ☒
Endocrine AMA Chapter 10	Yes ☐ No ☒
Diabetes AMA Chapter 10	Yes ☐ No ☒
Hearing AMA Chapter11	Yes ☐ No ☒
Sexual problems(AMA chapter 7 ,table 7-5,7-6,7-7,7-8 7 13-21)	Yes ☐ No ☒
Sleeping AMA Chapter 13	Yes ☐ No ☒
Eyes AMA Chapter 12 ,Chapter 13	Yes ☐ No ☒
Urinary problems AMA Chapter 6 ,13	Yes ☐ No ☒
Nerves AMA Chapter 13	Yes ☐ No ☒
a. Spinal Cord	Yes ☐ No ☒
b. Chronic Pain	Yes ☐ No ☒
c. Peripheral numbness or pain	Yes ☐ No ☒
d. Nueromuscular problems	Yes ☐ No ☒
Head AMA Chapter 13	Yes ☐ No ☒
Mental problems AMA Chapter 14 and GAF	Yes ☐ No ☒
Digestive system(chapter 6 ,table6-3,	Yes ☐ No ☒
Urinary System((chapter 7 ,table 7-1,7-2,7-3,7-4)	Yes ☐ No ☒
Blood ((chapter 9 ,table 9-2, 9-3,9-4)	Yes ☐ No ☒
Hormones(chapter 10 ,table tables 10-1 thru-10-9)	Yes ☐ No ☒
Diabetes (chapter 10 ,table 10-1 10-8-10-9)	Yes ☐ No ☒
Do you suffer from any problem with any other body part as a result of the injury?	Yes ☒ No ☐

If so, list the parts

1. Right Knee is the
2. injured part as a
3. result the left Knee
4. weakens. occassionaly
5. my hips are not
6. adjusted properly.
7.
8.
9.

Are you overusing another part of your body because of a problem with the injured body part? Yes ☒ No ☐
(i.e. you injured one arm and now you are overusing the other arm)

List the over used part(s)

1.
2. Left Knee
3.
4.
5.

As a result of the industrial injury:

Do you suffer from pain that travels from one part of the body to another(radiating pain) Yes ☐ No ☒
Where does it travel from and to?

	From	To
1.		
2.		
3.		
4.		

As a result of the industrial injury:

Have you gained weight since the industrial injury? Yes ☐ No ☐
If so how much weight have you gained? _____ Pounds

As a result of gaining weight are you having any physical problems? Yes ☐ No ☐

If you gained weight since the industrial injury have you had an echo cardiogram 2-D(Heart Test)? Yes ☐ No ☐

What results

If you gained weight have you had your blood pressure checked? Yes ☐ No ☐
What results:

If you gained weight have you been checked for diabetes? Yes ☐ No ☐

What results?

If you gained weight has your brain been checked for small strokes?
What results:?

Yes ☐ No ☒

If you gained weight have you been checked for sleep apnea?

Yes ☐ No ☒

What results:

If you gained weight have you been checked for sleep disturbance ?

Yes ☐ No ☒

As a result of Gaining weight are you having any Sexual Problems?

Yes ☐ No ☒

Are you less active since your injury?

Yes ☒ No ☐

As a result of being less active are you having any problems? Slight depression Weight gain

Yes ☒ No ☐

What problems are you having?
No control over circumstances

List those problems:
1. Can't commit to new employment due to unknown with old job
2. finances unstable
3. never thought I'd be off work this long
4. I could have graduated from trade school by now.
5.
6.
7.

Because of the increase of weight, has any doctor told you that you have an increase in salt and water retention?

Yes ☐ No ☒

Has any doctor told you that because you are taking any Non Steroidal anti-inflammatory drug you are retaining more salt and water in your system?

Yes ☐ No ☒

Has any doctor told you that you have lost muscle weight and replaced it with fat?

Yes ☐ No ☒

What secondary problems are you having or body part affected, as a result of the weight gain?
A.
B.
C.

D.
E.

Since your industrial injury have you had laboratory test done? Yes ☐ No ☒

If so, for what purpose:
1.
2.
3.
4

I guess I have it pretty good

As to Your Spine and or Neck and as a Result of the Industrial Injury:

Have You Had Flexion and Extension X-rays on Your Spine? Yes ☐ No ☒

Have You Had an MRI of the Spine? Yes ☐ No ☒

Have you had a Discogram Yes ☐ No ☒

Have you had a CT myelogram Yes ☐ No ☒

Have You Had Any Prior Back Surgeries? Yes ☐ No ☒

Do You Had Any Fractures of Your Spine Yes ☐ No ☒
If So, at What Level(s)

Do You Have Any Pain Going down Your Legs Yes ☐ No ☒
If So Which Leg(s)

Do You Have Headaches Yes ☐ No ☒

Do You Have Any Pain Going down Your Arms Yes ☐ No ☒

Do You Have Any Numbness down Your Arms or Legs Yes ☐ No ☒

Have You Had Surgery on Your Neck or Spine ? Yes ☐ No ☒
If So at What Level or Levels?_____

Have You Had a Fusion to Your Spine Yes ☐ No ☒
If So, at What Levels?_____

Since He Injury Do You Have Problems Walking Due
To Spinal Problems? Yes ☐ No ☒

Have You Had to Use a Cane and or Crutch to Help You Balance
Or Walk since the Industrial Injury Yes ☐ No ☒

As a Result of the Industrial Injury Do You Have Muscle Spasms? Yes ☐ No ☒

Have You Been Diagnosed with a Herniated Disk Yes ☐ No ☒

Have you been diagnosed with Spinal Stenosis? Yes ☐ No ☒

As a Result of the Industrial Injury:

Do You Suffer from Degenerative Disk Disease? Yes ☐ No ☒
If So, Where

As a Result of the Industrial Injury Do You Suffer from Arthritis? Yes ☐ No ☒
If So Where?

It is my job to identify ALL of the effects of your injury, and with serious back injuries ,the nerves are sometimes affected that relate to the bladder. This question is a bit personal, but do you notice changes in your bathroom habits, like you have to suddenly run to the bathroom, or feel like you have not gone all the way? Think carefully about whether anything has changed since your injury.

Yes ☐ No ☒

What problems are you having regarding bathroom habits?

As a Result of the Industrial Spinal Injury Do You Have
Any Corticospinal Tract Impairment(nerve Involvement
(Ama Ch. 13-table 13-15 15-table 15-6)) Such As: Yes ☐ No ☒

A. Gait, Balancing or Station Problems Ama Ch. 13-table 13-15,15-6) Yes ☐ No ☒

B. Urinary Incontinence Ama Ch. 13-table 13-19,13-6,15-6) Yes ☐ No ☒

C. Fecal Incontinence Ama Ch. 13-table 13-20,15-6) Yes ☐ No ☒

D. Sexual Problems (Ama Ch. 13-table 13-21),15-6) Yes ☐ No ☒

<u>Upper Extremities:Alone or as a result of spinal problems)</u>

As a Result of Your Injury Do You Have Nerve Damage in
Your Upper Extremities Yes ☐ No ☒

As a Result of Your Injury Do You Have Burning or Numbness in
Your Upper Extremities Yes ☐ No ☒

As a Result of Your Injury to Your Upper Extremity Do You Have:

Pain at Rest Yes ☐ No ☒

Pain with Activity Yes ☐ No ☒

Edema (Swelling of Legs) Yes ☐ No ☒
Vain Damage

Raynaud's Syndrome (Cold Fingers)(Ch.4,16) Yes ☐ No ☒

Loss of Strength Yes ☐ No ☒

Loss of Ability to Carry Yes ☐ No ☒

Loss of Ability to Lift Yes ☐ No ☒

Loss of Ability to Grip Yes ☐ No ☒

Loss of Ability to Grasp Yes ☐ No ☒

Arthritis in Joints Yes ☐ No ☒

Other Problems with Your Upper Extremities :
Be as Detailed as Possible:

Lower Extremities:Alone or as part of spinal problems

As a Result of the Injury to Your Lower Extremities Do You Suffer:

Gait or Station Derangement Yes ☐ No ☒

Muscle Atrophy Yes ☐ No ☒

Loss of Muscle Strength Yes ☐ No ☒

Peripheral Nerve Injury Yes ☐ No ☒

Numbness yes ☐ No ☒

Burning Yes ☐ No ☒

Vascular Problems (Peripheral) Yes ☐ No ☒

Need to Use a Cane or a Brace Yes ☐ No ☒

A Limp Yes ☐ No ☒

Immobile Joint Yes ☐ No ☒

Pain in Your Feet Yes ☐ No ☒

Arthritis Yes ☐ No ☒

Other problems with your lower extremities:
Be as detailed as possible:

Heart(chapter 3+4)
Even if you just have pain in your heart and chest since the industrial injury. Please ask your treating doctor to send you to a cardiologist for a check-up.

Since the injury have you been diagnosed with having any of the following problems or problems with the following body parts:

Valvular heart disease (ch.3,table 3-5) Yes ☐ No ☒

Lipid abnormality
(Low HDL and High LDL
High Triglyceride) Yes ☐ No ☒

Coronary heart disease(ch.3,table 3-6a) Yes ☐ No ☒

Congenital heart disease(ch.3, table 3-8) Yes ☐ No ☒

Cardiomyopathies(Heart Muscle problems)(ch.3, table 3-9) Yes ☐ No ☒

Pericardial heart disease((ch.3, table 3-10) Yes ☐ No ☒

Arrhythmia((ch.3, table 3-11) Yes ☐ No ☐

Atrial fibrillation Yes ☐ No ☐

Ventricle fibrillation Yes ☐ No ☐

Congestive Heart Failure Yes ☐ No ☐

Pericardial Heart Disease Yes ☐ No ☐

Hypertensive cardiovascular disease(ch.4, table 4-2) Yes ☐ No ☐

Aorta disease(ch.4, table 4-3) Yes ☐ No ☐

Vascular disease affecting extremities: Yes ☐ No ☐

Peripheral Vascular disease)upper extremities(ch.4, table 4-4) Yes ☐ No ☐

Peripheral Vascular disease)Lower extremities(ch 4, table 4-5) Yes ☐ No ☐

Raynaud's Phenomenon Yes ☐ No ☐

Problems in your veins? Yes ☐ No ☐

Pulmonary Arteries Disease (ch.4, table 4-6) Yes ☐ No ☐

Valvular Heart Disease? Yes ☐ No ☐

Claudication cramping in your leg(s) Yes ☐ No ☐

Edema in your legs? Yes ☐ No ☐

Left Ventricular Hypertrophy Yes ☐ No ☐

Hypertrophic(enlargedheart) Yes ☐ No ☐

Pulmonary Hypertension(ch.4, table 4-6) Yes ☐ No ☐

High Blood Pressure(chapter 4 ,table 4-2) Yes ☐ No ☐

Did you have any problems with your blood pressure before the industrial injury(AMA ch 4 table 4-2)) Yes ☐ No ☐

Have you had your blood pressure checked since the injury? Yes ☐ No ☐

Do you have any problem with your blood pressure since the industrial injury? Yes ☐ No ☐

Do you suffer from High Blood Pressure.(Hypertension)? Yes ☐ No ☐

Have you had any additional problems controlling your high blood pressure at any time since the injury? Yes ☐ No ☐

Do you suffer from Difficulty with Blood Pressure Control? Yes ☐ No ☐

Do you suffer from any end organ damage as a result of High blood pressure(hypertension)? Yes ☐ No ☐

Have you Suffered a Stroke since the injury?	Yes ☐ No ☒
Have you suffered a Myocardial Infarction?	Yes ☐ No ☒
Do you suffer from any Heart Disease	Yes ☐ No ☒
Do you suffer from Hypertrophy Cardiomyopathy	Yes ☐ No ☒
Do you suffer from an Heart Arrhythmia/palpitations	Yes ☐ No ☒
Do you suffer from Congenital heart disease	Yes ☐ No ☒
Do you suffer from Angina	Yes ☐ No ☒
Do you suffer from Hypertension with a Positive Echo Cardiogram	Yes ☐ No ☒
Do you suffer from Paroxysmal Tachycardia	Yes ☐ No ☒
Do you suffer from Other Heart Problems	Yes ☐ No ☒
Do you suffer from Diastolic Dysfunction As a Result of the industrial injury:	Yes ☐ No ☒
Do you suffer from High Triglyceride(blood fat)?	Yes ☐ No ☒
Have you had any surgery on your heart	Yes ☐ No ☒
Do you suffer from Atrial Fibrillation?	Yes ☐ No ☒
Do you suffer from pain in your heart	Yes ☐ No ☒
Do you suffer from Heart Palpitations	Yes ☐ No ☒
Do you suffer from any problems with your Arteries?	Yes ☐ No ☒
Do you have a history of having a heart attack?	Yes ☐ No ☒
Do you have heart Stints?	Yes ☐ No ☒
Have you had any Cardiovascular Surgeries?	Yes ☐ No ☒
Do you suffer from any Vascular Disease?	Yes ☐ No ☒
Do you suffer from swelling (edema) in feet or legs ?	Yes ☐ No ☒
Do you suffer from poor circulation to feet?	Yes ☐ No ☒
Do you suffer from Poor circulation to the hands?	Yes ☐ No ☒
Has any doctor told you have had heart failure?	Yes ☐ No ☒
Do you suffer from shortness of Breath ,with activity?	Yes ☐ No ☒

Do you suffer from shortness of breath without activity? Yes ☐ No ☒

Do you suffer from any kidney problems as a result of hypertension? Yes ☐ No ☒

Have you had any kidney function test since the ind. Injury? Yes ☐ No ☒

Heart and blood(chapter 3+4 and chapter 9)

Do you suffer from any dizziness Yes ☐ No ☒

Do you suffer from throbbing headaches? Yes ☐ No ☒

Do you suffer from frequent infections? Yes ☐ No ☒

Do you bruise easily? Yes ☐ No ☒

Do you have abnormal bleeding from your gums mouth? Yes ☐ No ☒

Do you suffer from drug related thrombocytopenia (Blood Clots) Yes ☐ No ☒

Do you take any blood thinning medication for your heart? Yes ☐ No ☒

Did You Had an Echo-cardiogram in the past 5 Years before the injury (AMA chapter 3 +4?) Yes ☐ No ☒

Have you had an Echo- Cardiogram since you had the injury? Yes ☒ No ☐ — due to heart murmur prior to test for knee 09

Have you had any other tests on your heart or any part thereof before the industrial injury(AMA ch. 3+4)? Yes ☐ No ☒
Which test?

Have you had any other test on your heart since the industrial injury? Yes ☐ No ☒

Which ones?

Sleep (chapter 13 ,table 13-4))

Do you suffer from Sleep Disturbance? Yes ☐ No ☒

Do you suffer from Day time drowsiness? Yes ☐ No ☒

Do you suffer from Reduction of day time alertness? Yes ☐ No ☒

Do you suffer from Sleep Apnea? Yes ☐ No ☒

Do you suffer from Inability to sleep due to pain? Yes ☐ No ☒

Do you suffer from Inability to sleep due to depression? Yes ☐ No ☒

Do you feel rested and restored when you wake up from sleeping? Yes ☐ No ☒

Do you feel better and more clear headed when you wake up from sleep? Yes ☐ No ☒

During the day do you fall to sleep while sitting and reading? Yes ☐ No ☒

During the day do you fall to sleep while watching television? Yes ☐ No ☒

During the day do you fall to sleep while sitting inactive in a public place (i.e. sitting in a theater or in a meeting) Yes ☐ No ☒

During the day do you fall to sleep while a passenger in a car for an hour with out a break? Yes ☐ No ☒

During the day do you fall to sleep lying down to rest in the afternoon? Yes ☐ No ☒

During the day do you fall to sleep sitting and talking to someone ? Yes ☐ No ☒

During the day do you fall to sleep after lunch without alcohol? Yes ☐ No ☒

During the day do you fall to sleep while stopped for a few minutes in traffic ? Yes ☐ No ☒

Do you take any medication that makes you sleepy during the day? Yes ☐ No ☒
if so what medication?
A.
B.
C.
D.
E

.

Nerve and painchapter 13:

Since the injury have you been diagnosed as having chronic pain one upper extremity(AMA Guides table 13-22 pg.343)? Yes ☐ No ☒

Since the injury have you been diagnosed as having chronic pain two upper extremity(AMA Guides table 13-17 pg.343)? Yes ☐ No ☒

Since the injury have you been diagnosed as having Gait and station problems (AMA Guides table 13-15)? Yes ☐ No ☒

Since the injury have you been diagnosed with Chronic Regional Pain Syndrome (AMA Guides table 13-22 pg.343)? Yes ☐ No ☒

Since the injury have you been diagnosed with Causalgia (burning pain in an extremity) (AMA Guides tables: 13-22 ,13-23,13-24? Yes ☐ No ☒

Since the injury have you been diagnosed with Post traumatic Neuralgia(sever pain along corse of nerve(AMA13-22)? Yes ☐ No ☒

Since you injury have you been diagnosed with claudication(muscle pain, cramping or pain in leg muscle ,AMA 13-23, 13-24, 17-38)? Yes ☐ No ☒

As a result of the industrial injury ,or as a consequence of the industrial injury:

Do you have any numbness in any part of your body? Yes ☒ No ☐

What part or parts of your body?

R. Knee, tingle & numb

Nerve damage, Yes ☐ No ☐ ?

Perperipheral nerve damage
(AMA Guides Ch 4 table4-4,4-5,13-23,16-10,16-17)? Yes ☐ No ☐

Diabetic neuropathy(Nerve damage) Yes ☐ No ☐

Peripheral vascular disease Yes ☐ No ☐

Do you suffer from Central and Peripheral Nervous system problems such as:

Myofascial Pain Syndrome Yes ☐ No ☐

Fibromyalgia Yes ☐ No ☐

Chronic extremity pain syndromes Yes ☐ No ☐

Dizziness Yes ☐ No ☐

Paralysis Yes ☐ No ☐

Stroke Yes ☐ No ☐

Do you suffer from any Stress and Stress related illness? Yes ☐ No ☐

Do you suffer from Depression? Yes ☐ No ☐

Do you suffer from Headaches or Migraines? Yes ☐ No ☐

Do you suffer from Tension Headaches Yes ☐ No ☐

Do you suffer from any Cerebral impairments? Yes ☐ No ☐

Do you suffer from seizures? Yes ☐ No ☐

Do you suffer from epilepsy? Yes ☐ No ☐

Do you suffer from cognitive problems? Yes ☐ No ☐

Do you suffer from Memory loss? Yes ☐ No ☐

Do you suffer from an inability to word select? Yes ☐ No ☐
Do you suffer from problems in word scanning? Yes ☐ No ☐

Do you suffer from interpret what is said to you ? Yes ☐ No ☐

Digestive 6.
Since your injury do you suffer from Digestive System problems? Yes ☐ No ☐

Since your injury do you suffer from any Gastrointestinal disorders? Yes ☐ No ☒

Since your injury do you suffer from Stomach problems? Yes ☐ No ☒

Since your injury do you suffer from the effects of medication on your upper and /or lower gastrointestinal tract? Yes ☐ No ☒

Do you suffer from effects of chronic stress and pain on the digestive tract? Yes ☐ No ☒

Do you suffer from a duodenal and or peptic ulcer? Yes ☐ No ☒

Since your injury do you suffer from Incontinence (Fecal or urinary)? Yes ☐ No ☒

Since your injury do you suffer from Constipation? Yes ☐ No ☒

Since your injury do you suffer from Diarrhea? Yes ☐ No ☒

Since your injury do you suffer from Gastric Esophageal Reflux Disease (GERD)? Yes ☐ No ☒

If you suffer from GERD, have you lost weight from Same? Yes ☐ No ☒

Have you had any surgery because of the GERD? Yes ☐ No ☒

Are you taking Medication for the GERD? Yes ☐ No ☒

Do you suffer from Mucous Colitis? Yes ☐ No ☒

Do you suffer from Irritable Bowel Disease? Yes ☐ No ☒

Since your injury do you suffer from Gastritis? Yes ☐ No ☒

Since your injury do you suffer from Heartburn? Yes ☐ No ☒

Since your injury do you suffer from Nausea? Yes ☐ No ☒

Since your injury do you suffer from Vomiting? Yes ☐ No ☒

Since your injury do you suffer from Blood in stools? Yes ☐ No ☒

Do you suffer from Hemorrhoids? Yes ☐ No ☒

Since your occupational injury do you suffer from Increased Alcohol and/or drug use? Yes ☐ No ☒

Do you suffer from fatty liver infiltration? Yes ☐ No ☒

Do you suffer from Non -Alcohol fatty degeneration with inflammation and hepatocyte(liver) necrosis? Yes ☐ No ☒

Do you suffer from Hepatitis? Yes ☐ No ☒

Did you have any Stomach or bowel, or digestive problems before the industrial injury(AMA Chapter 6)? Yes ☐ No ☒

Since the injury you have any Stomach or bowel or digestive problems(AMA Ch.6 table 6-3)? Yes ☐ No ☒

Prior to the injury did you have problems with your upper digestive tract (Esophagus, Stomach, Duodenum, Small intestine and Pancreas)? Yes ☐ No ☒

Since the industrial injury have you had any problems with your upper digestive tract(AMA Ch.6 table 6-3)? (Esophagus, Stomach, Duodenum, Small intestine and Pancreas) Yes ☐ No ☒

Have you been tested for any stomach or bowel problems since the industrial injury Yes ☐ No ☒

Before the injury did you have any problems with your Colon , Rectum and Anus(AMA Chapter6 Table 6-3, 13-7c))? Yes ☐ No ☒

Have you had a colonoscopy since the industrial injury? Yes ☐ No ☒

Did you suffer from fecal incontinence before the industrial injury (AMA Guides Ch 6 table 6-5)? Yes ☐ No ☒

Do you suffer from fecal incontinence since the industrial injury(AMA Guides Ch 6 table 6-5)? Yes ☐ No ☒

Did you suffer from constipation prior to the industrial injury(AMA Guides Ch 6 table 6-4) ? Yes ☐ No ☒

Do you suffer from constipation Since the industrial injury? Yes ☐ No ☒

For your injury have you taken any Non Steroidal Anti Inflammatory Medication in the past Five Years? Yes ☐ No ☒

If so have you had any stomach or bowel problems as a result thereof? Yes ☐ No ☒

Do you take any Non steroid anti inflammatory medication Yes ☐ No ☒

If so has it affected your digestion in any way? Yes ☐ No ☒

Prior to the injury did you suffer from any Hernias(AMA Guides Ch 6 table6-9)? Yes ☐ No ☒

Since the industrial Injury do you suffer from any Hernias (AMA Guides Ch 6 table6-9)? Yes ☐ No ☒

Did you have any problems with your liver before the industry injury(AMA ch.6.5 table 6-7)? Yes ☐ No ☒

Have you had any tests on your Liver since the industrial injury(AMA Ch.6,table 6-7,6-8)? Yes ☐ No ☒

Injury 9.08

Have you had your liver checked since the industrial injury? Yes ☒ No ☐

Lungs and Respiratory

Prior to your injury did you have any lung or respiratory problems AMA CH.5 table 5-9--5-10)? such as: Yes ☐ No ☒

Obstructive. asthma(chapter 5 ,table5-9-5-10-5-12) Yes ☐ No ☒

Restrictive pulmonary fibrosis(chapter 5-table 5-12) Yes ☐ No ☒

Lung Cancer((chapter 5 ,table 5-11) Yes ☐ No ☒

Other lung or respiratory problems: List

Since your industrial injury have you had any testing for lung and or respiratory problems (AMA ch 5-table 5-12, 13-18)? Yes ☐ No ☐

Since the industrial injury do you have any lung or respiratory problems AMA CH.5 table 5-9--5-10)? such as: Yes ☐ No ☒

Obstructive. asthma(chapter 5 ,table5-9-5-10-5-12) Yes ☐ No ☒

Restrictive pulmonary fibrosis(chapter 5-table 5-12) Yes ☐ No ☒

Lung Cancer((chapter 5 ,table 5-11) Yes ☐ No ☒

Other lung or respiratory problems: List

Do you suffer from lung problems as a result of second hand smoke from the work place? Yes ☐ No ☒

Do you smoke cigarettes? Yes ☐ No ☒

Did you smoke cigarettes with in the last twenty years? Yes ☐ No ☒

Did you quit smoking cigarettes within the past ten years? Yes ☐ No ☒

As A result of the injury, and or any medication you are taking for the industrial injury :

Do you suffer from Asthma?

Do you suffer Small Airways disease? Yes ☐ No ☒

Do you suffer from Chronic Obstructive Pulmonary Disease? Yes ☐ No ☒

Do you suffer from Shortness of breath? Yes ☐ No ☒

Do you suffer from Emphysema Yes ☐ No ☒

Do you Cough up blood? Yes ☐ No ☒

Urinary 7

Do you suffer from problems with your Urinary and Reproductive system? Yes ☐ No ☒

Did you suffer from any sexual dysfunction before the industrial injury(AMA Guides Ch.7.7 table 7-5,13-21)? Yes ☐ No ☒

Do you suffer from any sexual dysfunction since the industrial injury(AMA Guides Ch.7.7 table 7-5,13-21)? Yes ☐ No ☒

Do you suffer from Sexual dysfunction with:

- Problems with Orgasm **(Woman)** Yes ☐ No ☒
- Problems with Lubrication**(Woman)** Yes ☐ No ☒
- Problems with Ejaculation**(Men)** Yes ☐ No ☒
- Problems with Erection **(Men)** Yes ☐ No ☒
- Other deficits in Sexual Function that you Noted. Please List

Have you discussed this with your Doctor? Yes ☐ No ☒

Has he or she said the sexual dysfunction is related to the industrial injury and or any medication you are taking for the industrial injury? Yes ☐ No ☒

Has he or she said the sexual dysfunction is related to depression resulting from the industrial injury? Yes ☐ No ☒

Has he or she said the sexual dysfunction is related to nerve damage resulting from the industrial injury? Yes ☐ No ☒

Since the industrial injury do you suffer from Kidney problems such as:

- Difficulty in urinating Yes ☐ No ☒
- Prostate problems Yes ☐ No ☒
- Renal disease Yes ☐ No ☒
- Frequent urination Yes ☐ No ☒

Did you have any kidney problems before the industrial injury(AMA Ch.7 table 7-1,7-37-4)? Yes ☐ No ☒

Have you had any kidney problems do to a medication

you are taking for the industrial injury? Yes ☐ No ☒

Have you had your kidneys checked or tested since the industrial injury? Yes ☐ No ☒

Have you had any problems with your Urinary tract since the industrial injury(AMA ch.7-table 7-1)? Yes ☐ No ☒

Since the injury have you had any bladder problems(AMA CH.7-Table 7-3, 13-19)? Yes ☐ No ☒

Since the ind. Injury have you had any Urethra problems (AMA ch.7-table 7-4)? Yes ☐ No ☒

Did you suffer from any urinary incontinence before the industrial injury? Yes ☐ No ☒

Do you suffer from urinary incontinence since the industrial injury(AMA Ch.7 table 7-5? Yes ☐ No ☒

Endocrine system(chapter 10)

Since the injury have you developed diabetes Yes ☐ No ☒

Do you take medication for your diabetes? Yes ☐ No ☒

Do you suffer from any end organ damage as a result of the diabetes? Yes ☐ No ☒

Have you had any problem or additional problem with your diabetes since your injury? Yes ☐ No ☒

Do you have a abnormal insulin response? Yes ☐ No ☒

Have you had a head trauma that resulted in Diabetes Insipidus ? Yes ☐ No ☒
(Traumatic diabetes chapter 10-215)

Did you have diabetes before the industrial injury Yes ☐ No ☒

Have you been checked for diabetes(AMA ch.10 table 10-8) since the industrial injury? Yes ☐ No ☒

Do you have any diabetic since the industrial injury? Yes ☐ No ☒

Do you suffer from any thyroid disease? Yes ☐ No ☒

If so has it been made worse since the industrial injury Yes ☐ No ☒

As a result of the injury have you had any hormone problems Yes ☐ No ☒

Do you suffer from problems such as

Diabetes Mellitus(due to excessive weight gain
associated with decreased physical activity and/ or caused
by chronic pain and/or anatomical dysfunction
or due to medication effects)

Yes ☐ No ☐

Do you suffer from a Metabolic system problems
such as (insulin resistance syndrome)
or a combination of three of the following — Yes ☐ No ☐

Obesity — Yes ☐ No ☐

Resistance to insulin — Yes ☐ No ☐

Hypertension — Yes ☐ No ☐

Gastrointestinal Problems — Yes ☐ No ☐

Do you suffer from an auto immune disease
or auto immune allergy? — Yes ☐ No ☐

Skin 8
As a result of the injury or medication you are taking for the injury
injury do you suffer from skin problems such as? — Yes ☐ No ☐

Cancer — Yes ☐ No ☐

Dryness — Yes ☐ No ☐

Rash — Yes ☐ No ☐

Itching — Yes ☐ No ☐

Burning — Yes ☐ No ☐

Scars — Yes ☐ No ☐

Pressure Ulcers — Yes ☐ No ☐

Eczema — Yes ☐ No ☐

Psoriasis — Yes ☐ No ☐

Reddening of the skin — Yes ☐ No ☐

Swollen or raised area of your skin — Yes ☐ No ☐

Hives — Yes ☐ No ☐

Allergic reaction to medication — Yes ☐ No ☐

Other skin Problems — Yes ☐ No ☐

Do you suffer from Impairment of vision? — Yes ☐ No ☐

Do you suffer from Teeth problems? Yes ☐ No ☒

Do you suffer from Jaw problems? Yes ☐ No ☒

Do you suffer from Temporo Mandibular Joint(TMJ) Syndrome problems? Yes ☐ No ☒

Do you have problems chewing your food? Yes ☐ No ☒

Do you suffer from Dry mouth (Xerostomia)? Yes ☐ No ☒

Do you suffer from hearing loss Yes ☐ No ☒

Ringing in your ears Yes ☐ No ☒

Blood 9

As a result of the industrial injury do you suffer from problems with the blood system? Yes ☐ No ☒

Such as:

enlarged spleen Yes ☐ No ☒

Hodkins disease Yes ☐ No ☒

HIV infection Yes ☐ No ☒

blood clotting defect Yes ☐ No ☒

frequent nose bleeds Yes ☐ No ☒

severe or frequent blood clots Yes ☐ No ☒

Do you take any blood thinning drugs such as Coumadin Yes ☐ No ☒

Do you suffer from anemia caused by chronic disease? Yes ☐ No ☒

Do you suffer from Iron deficiency anemia? Yes ☐ No ☒

Do you suffer from any Blood Clots Yes ☐ No ☒

Do you suffer from Blood or platelet disorders Yes ☐ No ☒

Do you suffer from impairment due to a white blood disease Yes ☐ No ☒

Do you suffer from Anemia Yes ☐ No ☒

Do you suffer from Weakness and Night Sweats Yes ☐ No ☒

Do you suffer from progressive fatigue Yes ☐ No ☒

Do you suffer from any problem with your spleen Yes ☐ No ☒

As a result of a blood transfusion, do you suffer from HIV Yes ☐ No ☒

If you suffered from HIV before the injury, has the injury made your condition worse? Yes ☐ No ☒

Do you bruise easily Yes ☐ No ☒

Do you suffer from any problem, since the industrial injury in the following areas:

Defecating	Yes ☐ No ☒
Bathing	Yes ☐ No ☒
Brushing teeth	Yes ☐ No ☒
Combing Hair	Yes ☐ No ☒
Dressing ones Self	Yes ☐ No ☒
Washing and drying oneself	Yes ☐ No ☒
Getting on and off the toilet	Yes ☐ No ☒
Opening a carton of Milk	Yes ☐ No ☒
Making your one meal	Yes ☐ No ☒
Eating	Yes ☐ No ☒
Cutting your own food	Yes ☐ No ☒
Writing	Yes ☐ No ☒
Typing	Yes ☐ No ☒
Using a Telephone	Yes ☐ No ☒
Seeing	Yes ☐ No ☒
Hearing	Yes ☐ No ☒
Speaking	Yes ☐ No ☒
Standing	Yes ☐ No ☒
Sitting	Yes ☐ No ☒
Reclining	Yes ☐ No ☒
Walking	Yes ☐ No ☒

Climbing Stairs	Yes ☒ No ☐
Hearing	Yes ☐ No ☒
Seeing	Yes ☐ No ☒
Tactile Feeling	Yes ☐ No ☒
Tasting	Yes ☐ No ☒
Smelling	Yes ☐ No ☒
Grasping	Yes ☐ No ☒
Lifting	Yes ☐ No ☒
Tactile discrimination	Yes ☐ No ☒
Opening a Car Door	Yes ☐ No ☒
Turning on a Faucet	Yes ☐ No ☒
Riding	Yes ☐ No ☒
Doing Light House Work	Yes ☐ No ☒
Running Errands	Yes ☐ No ☒
Riding in A Car	Yes ☐ No ☒
Shopping	Yes ☐ No ☒
Driving	Yes ☒ No ☐
Fear of Flying	Yes ☐ No ☒

Leg Swells

Leg Swells

Other Body System problems Not mentioned above: Yes ☐ No ☐

Please list

1. I think you about
2. Covered it all
3.
4.
5.

Please take a copy of the filled out checklist to your treating doctor and please return this list to this office so that we can file or amend your claim(s)

nt your Name:

Tiffany Anderson (Print) **Date:** 10-8-2009

. ... out this form and make a copy for the doctor and this office. Keep a copy for your self

Prior to the date of injury how long were you working for the employer? 4 years

What was your occupation (job title) for your employer Technician I Pesticide applicator

Please list every body part that you believe was affected (not as a specific injury) but over a period of time(cumulative injury) as a result of the work you did for your employer? (*For example my back and legs began to bother me as a result of the work I did for my employer*)

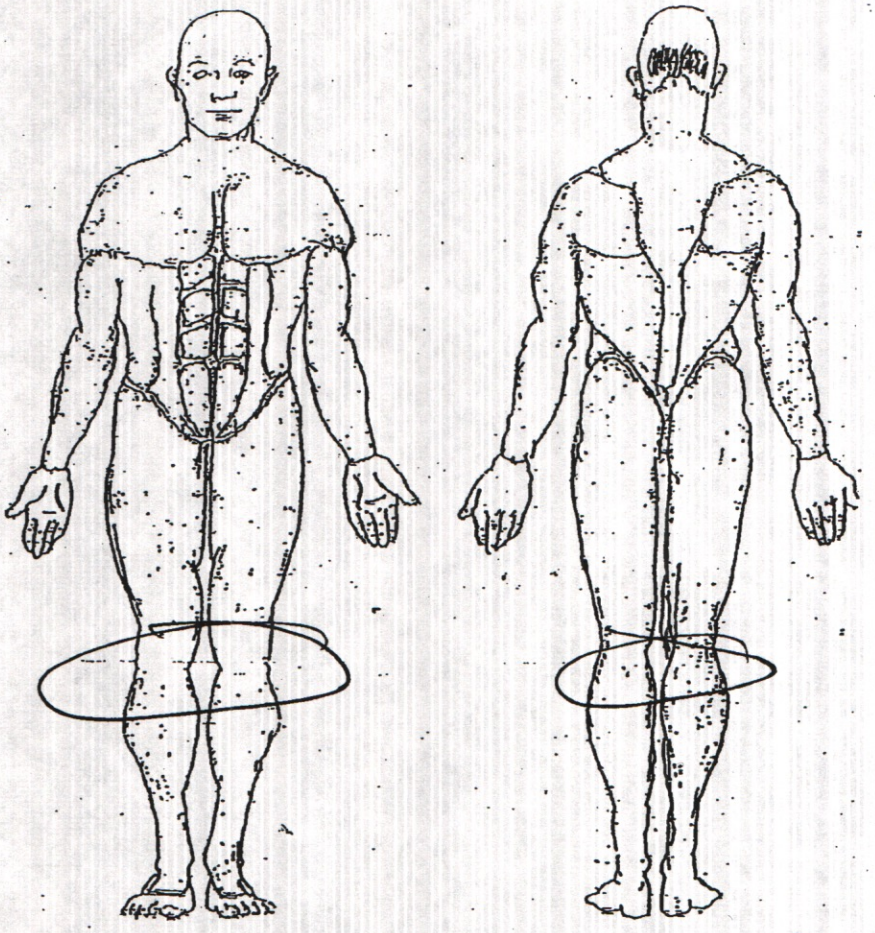
My Shoulders, scapula, neck, head, Knees
Emotions

List every problem from head to toe that you are having as a result of your injury and/or as a result of the treatment you are receiving, and/or as a result of medication you are taking for your injury.

Knees

Right Knee Swollen and injured
left Knee Weakning as a result of
dealing with the majority of work or
Stress requirement from everyday use.
9-22-2008

Please mark the body parts where you are having problems NOW, as a result of the industrial injury and/or treatment from the industrial injury. List every part. Do not leave any part out.



P for Pain, N for Numbness, S for Swelling, B for Burning, T for Tingling, W for Loss of Strength (weakness), R for slow or Lost Reflexes, M for Tense Injured or Sensitive Muscles, and O for other.

Please circle the level of pain you are experiencing on the scale below:

1.	2.	3.	(4.)
Minimal	Slight	Moderate	Severe

Have you had any previous surgeries? ☒ yes ☐ no

If yes, please explain: Injury 1 resulted in Orthoscopic Surgery

Please mark those that apply that were caused by the industrial injury and or the treatment of same .

Psycho/Social:

- ☐ No Problems
- ☐ Are you anxious?
- ☐ Are you depressed?

Skin:

- ☐ No Problems
- ☐ Dryness
- ☐ Rash
- ☐ Itching
- ☐ Burns
- ☐ Scars
- ☐ Pressure Ulcers

Eye, Ear, Nose, Throat:

- ☐ No problems
- ☐ Do you Have A hearing loss?
- ☐ Wear Hearing Aids?
- ☐ Do you have any visual deficits?
- ☐ Wear Glasses or contact lenses?

Neuro:

- ☐ No problems
- ☐ Head Aches
- ☐ Seizures
- ☐ Dizziness
- ☐ Paralysis
- ☐ Stroke

Respiratory:

- ☐ No problems
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Cough up blood
- ☐ Chronic Obstructive Pulmonary disease

Cardiovascular:

- ☐ No Problems
- ☐ Angina
- ☐ High blood pressure
- ☐ History of heart attack
- ☐ Stints
- ☐ Cardiovascular Surgeries
- ☐ Edema in feet or legs (Swelling)
- ☐ Poor circulation to feet

Gastrointestinal/ Endocrine:

- ☒ No problems
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Blood in stools
- ☐ Hemorrhoids
- ☐ Diabetes
- ☐ Controlled Diet
- ☐ Use Medication for Diabetes
- ☐ Thyroid disorders
- ☐ Steroid Use

Gu/Gyn:

- ☒ No problems
- ☐ Incontinence
- ☐ Pregnant
- ☐ Difficulty in urinating
- ☐ Prostrate problems
- ☐ Renal disease
- ☐ Frequent urination
- ☐ Sexual Dysfunction

Musculoskeletal:

- ☒ No problems
- ☐ Fractures
- ☐ History of back problems prior to injury
- ☐ Back surgeries
- ☐ Carpel tunnel problems
- ☐ Arthritis
- ☐ Prosthesis
- ☐ Degenerative Disc Disease

List all problems that you are having in the following areas of daily activity as a result of the industrial injury and or treatment of same:

ACTIVITY	EXAMPLE
Self-care, personal hygiene	Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating.
Communication	Writing, typing, seeing, hearing, speaking
Physical activity	standing, sitting, reclining, walking, climbing stairs
Sensory function	Hearing, seeing, tactile feeling, tasting, smelling
Nonspecialized hand activities	Grasping, lifting, tactile discrimination
Travel	Riding, driving, flying
Sexual function	Orgasm, ejaculation, lubrication, erection
Sleep	Restful, nocturnal sleep pattern

I can no longer run, exercise, do basic Yoga or pilates my knee is in severe pain and I do not know why.

List ALL of your current medications: Norco, Xanax, IB profin

List ALL side effects from the medications: ?

Do you have any other special medical problems that we need to be aware of ?

migraine headaches

This part of the questionnaire helps us to understand how much your industrially caused pain has affected you ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1- Pain Intensity & where your pain is.

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☒ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

- [x] I can lift heavy weights without extra pain. not while standing or squatting
- [ ] I can lift heavy weights but it gives extra pain.
- [ ] Pain prevents me from lifting heavy weights off the floor.
- [ ] Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- [ ] Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- [ ] I can only lift weights at the most.

SECTION 4 - Walking

- [ ] I have no pain on walking.
- [ ] I have some pain on walking but it does not increase with distance.
- [ ] I cannot walk more than one mile without increasing pain.
- [ ] I cannot walk more than ½ mile without increasing pain.
- [ ] I cannot walk more than 1/4 mile with out increasing pain.
- [x] I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- [ ] I can sit in any chair as long as I like without pain.
- [ ] I can sit only in my favorite chair as long as I like.
- [ ] Pain prevents me from sitting more than 1 hour.
- [x] Pain prevents me from sitting more than ½ hour.
- [ ] Pain prevents me from sitting for more than 10 minutes.
- [ ] I avoid sitting because it increases pain immediately.

SECTION 6 - Standing

- [ ] I can stand as long as I want without pain.
- [ ] I have some pain on standing, but it does not, increase with time.
- [ ] I cannot stand for longer than one hour without increasing pain.
- [ ] I cannot stand for longer than ½ hour without increasing pain.
- [ ] I cannot stand for longer than 10 minutes without increasing pain.
- [x] I avoid standing, because it increases the pain immediately.

SECTION 7 - Sleeping I take sleep aid Xanax & pain pills b.c baby

- [ ] I get no pain in bed.
- [ ] I get pain in bed but it does not prevent me from sleeping well.
- [ ] Because of pain, my normal night's sleep is reduced by less than 1/4.
- [ ] Because of pain, my normal night's sleep is reduced by less than ½.
- [x] Because of pain, my normal night's sleep is reduced by less than 3/4.
- [ ] Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- ☐ My social life is normal and gives me no 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., dancing, etc.
- ☒ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.
- ☐ I am experiencing sexual dysfunction as a result of the industrial injury.

SECTION 9 - Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms, of travel.
- ☒ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow.
- ☐ My pain is neither getting better nor getting worse.
- ☒ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

SECTION 11

- ☐ Sexual Function.
- ☐ Orgasm.
- ☐ Ejaculation.
- ☐ Lubrication.
- ☐ Erection.
- ☐ Loss of interest in Sex.

Please give your opinion as it pertains to Your functional capacity and Your ability to do your job **existing** at this time.

Circle the full capacity for each activity.

I. **Total time during an 8-hour workday You can:** intervals

A. Sit	- Number of hours:	1	2	(3)	4	5	6	7	8
B. Stand	- Number of hours:	1	2	(3)	4	5	6	7	8
C. Walk	-Number of hours:	1	2	(3)	4	5	6	7	8

II. **Total during the entire 8 - hour day You can:** guessing

A. Sit	- Number of hours:	1	2	3	4	5	6	(7)	8
B. Stand	- Number of hours:	(1)	2	3	4	5	6	7	8
C. Walk	-Number of hours:	1	(2)	3	4	5	6	7	8

In terms of an 8 - hour workday, "occasionally" equals 1% to 33%; "frequently" equals 34% to 66%; and "continuously" equals 67% to 100%.

III. **Your ability to :**

	Not at All	Occasionally	Frenquently	Continually
A. Bend/Stoop	—	X	—	—
B. Squat	—	X	—	—
C. Crawl	X	—	—	—
D. Climb	—	X	—	—
E. Reach Above	—	—	—	X
F. Crouch	—	—	—	—
G. Kneel	—	—	—	—
H. Balance	—	—	—	X
I. Push/Pull	—	—	—	X

IV. **You can lift:**

	Not at All	Occasionally	Frenquently	Continually
A. Up to 10 lbs	—	—	X	—
B. 11 to 24 lbs.	—	—	X	—
C. 25 to 34 lbs.	—	—	X	—
D. 35 to 50 lbs.	—	—	X	—
E. 51 to 74 lbs.	—	X	—	—
F. 75 to 100 lbs.	—	X	—	—

maybe?

(Continued)

V. **Your pre-injury capacity for lifting:**

	Not at All	Occasionally	Frequently	Continuously
A. Up to 10 lbs	—	—	—	X
B. 11 to 24 lbs.	—	—	—	X
C. 25 to 34 lbs.	—	—	—	X
D. 35 to 50 lbs.	—	—	X	—
E. 51 to 74 lbs.	—	X	—	—
F. 75 to 100 lbs.	—	X	—	—
G. 101 to 149 lbs.	X	—	—	—

? Guessing maybe not

H. 150 to 175 lbs.	X	—	—	—
I. 176 to 200 lbs.	X	—	—	—

VI **You can NOW carry:**

	Not at All	Occasionally	Frequently	Continuously
A. Up to 10 lbs	—	—	X	—
B. 11 to 24 lbs.	—	X	—	—
C. 25 to 34 lbs.	—	X	—	—
D. 35 to 50 lbs.	X	—	—	—
E. 51 to 74 lbs.	X	—	—	—
F. 75 to 100 lbs.	X	—	—	—

VII. **Your pre-injury capacity for carrying:**

	Not at All	Occasionally	Frequently	Continuously
A. Up to 10 lbs	—	X	—	—
B. 11 to 24 lbs.	—	X	—	—
C. 25 to 34 lbs.	—	X	—	—
D. 35 to 50 lbs.	—	X	—	—
E. 51 to 74 lbs.	X	—	—	—
F. 75 to 100 lbs.	X	—	—	—
G. 101 to 149 lbs.	X	—	—	—
H. 150 to 175 lbs.	X	—	—	—
I. 176 to 200 lbs.	X	—	—	—

Please give your opinion as it pertains to the percentage of the capacity for lifting that you feel you have lost.

In your opinion, how much of the Your capacity for lifting has been lost?

A. 0%
B. 1% - 10%
C. 11% - 20%
D. 21% - 30%
E. 31-40%
F. 41-50%
G. 51-60%
H. 61-70%
I. 71-80%
J. 81-90%
K. 91-100%

VII. **You can use feet for repetitive movement as in operating Foot controls:**

Right: X Yes — No
Left: X Yes — No
Both: X Yes — No

leg swells as result

VIII. **You can use hands for repetitive movement such as:**

A. Simple Grasping Right: X Yes Left: X Yes
__ No __ No

B. Firm Grasping Right: X Yes Left: X Yes
__ No __ No

C. Fine Manipulation Right: X Yes Left: X Yes
__ No __ No

VIIII. **Restriction of Activities:**

A. Unprotected Heights:

No Restriction	Mild Restriction	Moderate Restriction	Total Restriction
__	X	__	__

I do not like heights nothing to do with injury

B. Being around moving machinery:

No Restriction	Mild Restriction	Moderate Restriction	Total Restriction
__	__	X	__

do not like

C. Exposure to marked changes in temperature and humidity:

No Restriction	Mild Restriction	Moderate Restriction	Total Restriction
__	X	__	__

used to work in refridgeration

D. Driving automotive equipment:

No Restriction	Mild Restriction	Moderate Restriction	Total Restriction
__	X	__	__

E. Exposure to dust, fumes and gasses:

No Restriction	Mild Restriction	Moderate Restriction	Total Restriction
__	__	X	__

do not like

F. Other restrictions not other wise specified.

Standing for small lengths of time.

I. Pain (Self-report of Severity)

A. Rate how severe your pain is right now, at this moment (circle a number):

0 1 2 3 4 5 6 (7) 8 9 10

No pain — Most severe pain can imagine

B. Rate how severe your pain is at its worst (circle a number):

0 1 2 3 4 5 6 7 8 9 (10)

None — Excruciating

C. Rate how severe your pain is on the average (circle a number):

0 1 2 3 4 5 6 (7) 8 9 10

None — Excruciating

D. Rate how much you pain is aggravated by activity (circle a number):

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 (circle a number):

0 1 2 3 4 5 6 (7) 8 9 10

Rarely — All of the time

II. Activity Limitation or Interference

A. How much does your pain interfere with your ability to walk 1 block? (circle a number)

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

I can do it, my leg swells as a result

B. How much does your pain prevent you from lifting 10 pounds (a bag of groceries)?(circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not prevent from lifting 10 pounds

Impossible to lift 10 pounds

C. How much does you pain interfere with your ability to sit for ½ hour? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to sit for ½ hour

Impossible to sit for ½ hour

D. How much does your pain interfere with your ability to stand for ½ hour? (Circle a number):

0 1 2 3 4 5 6 7 8 9 10

Pain does not interfere with ability to stand at all

Unable to stand at all

E. How much does your pain interfere with your ability to get enough sleep? (Circle a number): drugs used to accomplish this

0 1 2 3 4 5 6 7 8 9 10

Does not prevent me from sleeping

Impossible to sleep to sleep

F. How much does your pain interfere with your ability to participate in social activies? (Circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with social activities

Completely interfere with social activities

G. How much does you pain interfere with your ability to travel up to 1 hour by car? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with ability to travel 1 hour by car

completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your daily activities? (circle a number):

0 1 2 3 4 5 6 (7) 8 9 10

Does not interfere with my daily Activities — completely limits with my daily activities

I. How much do you limit you activities to prevent your pain form getting worse? (circle a number):

0 1 2 3 4 5 6 7 8 9 (10)

Does not limit activities — Completely interferes activities

J. How much does your pain interfere with your relationship with your family / partner / significant others? (circle a number):

0 1 2 3 4 5 6 7 8 9 (10)

Does not interfere with relationships — Completely interferes with relationships

my family whines does not understand

K. How much does your pain interfere with your ability to do jobs around your home? (circle a number):

0 1 2 (3) 4 5 6 7 8 9 10

Does not interfere — completely unable to do any job around home

L. How much does your pain interfere with your ability to shower or bathe without help from someone else? (circle a number):

(0) 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to shower or bathe without help

M. How much does your pain interfere with your ability to write or type? (circle a number):

(0) 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it Impossible to write or type

N. How much does your pain interfere with your ability to dress yourself? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it Impossible to dress myself

O. How much does your pain interfere with your ability to engage in sexual activities? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it almost impossible to engage in any sexual activity

P. How much does your pain interfere with your ability to concentrate? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Never — All the time

III. Individual's Report of Effect of Pain on Mood

A. Rate your overall mood during the past week. (circle a number):

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? (circle a number):

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 anxious or worried have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all depressed — Extremely depressed

D. During the past week, how irritable have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

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

0 1 2 (3) 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

no worry just don't do them

Signed [signature]

Dated 10.8.2009

Since I have been removed from work I am a ~~better~~ well rounded person who is much happier.