RiversEdge Orthopedics
3318 N. Grand Mill Lane
Coeur d'Alene, ID 83814
208-277-1060/ 277-1065 (fax)

INDEPENDENT MEDICAL EVALUATION
DEMOGRAPHICS and CONSENT

PATIENT INFORMATION:

Full Name: ______________________________ DOB:____________ Sex: ______

Address______________________________ City________________ State________ Zip:__________

Phone#: ________________ Alt. Phone#: ________________ SS#: ________________

Race:__________ Ethnicity:______________ Email: ______________________________

Name and address of Employer____
(AT TIME OF INJURY)

____Emergency Contact__________________

Occupation: ________________ Employment Status: FT PT Not Emp Retired

Workman's Comp Carrier: ____________________________ Claim #__________________

Name of Adjuster:______________________________ Date of Injury: ______________

SIGNED:____ **DATE:**______________

IME Informed Consent

Please read and **initial** each yellow box. Thank you!

OFFICE POLICY FOR THIS OFFICE IS AS FOLLOWS: CLAIMANT WILL BE THE ONLY PERSON ALLOWED IN EXAM ROOM DURING EXAMINATION WITH THE DOCTOR & HIS MEDICAL ASSISTANT. SPOUSES, FRIENDS, RELATIVES, THERAPISTS, OR ANY OTHER PERSONNEL WILL NOT BE PERMITTED. AUDIO/VIDEO RECORDING IS NOT ALLOWED. THIS EXAMINATION DOES NOT CONSIST OF PATIENT TREATMENT OR MEDICAL ADVICE RENDERED. THE IME REPORT WILL BE SENT TO THE ORDERING PARTY ONLY.

I understand that I am being seen for an Independent Medical Examination for an impartial assessment of my orthopedic condition.

I understand that during the course of this exam, I will not do anything that I feel will cause me any injury or discomfort, and I will advise the physician immediately if I experience any difficulties.

I understand no Physician – Patient relationship is established. Nor will I be able to call Dr. Greendyke to discuss his findings after this examination.

This Examination has been requested by ______________________________, and a report will be sent to this client. I will not contact RiversEdge for a copy of the report, but will contact who requested this exam to discuss any finding or to get a copy of the report.

I consent to this report being sent to this client, and to those participating in the assessment.

______________________________________ Date:____________________

Signature of Examinee

____

IME Intake Form

Date:______________

Name: ______________________________________ DOB: ________________ Age:________

REVIEW OF SYSTEMS

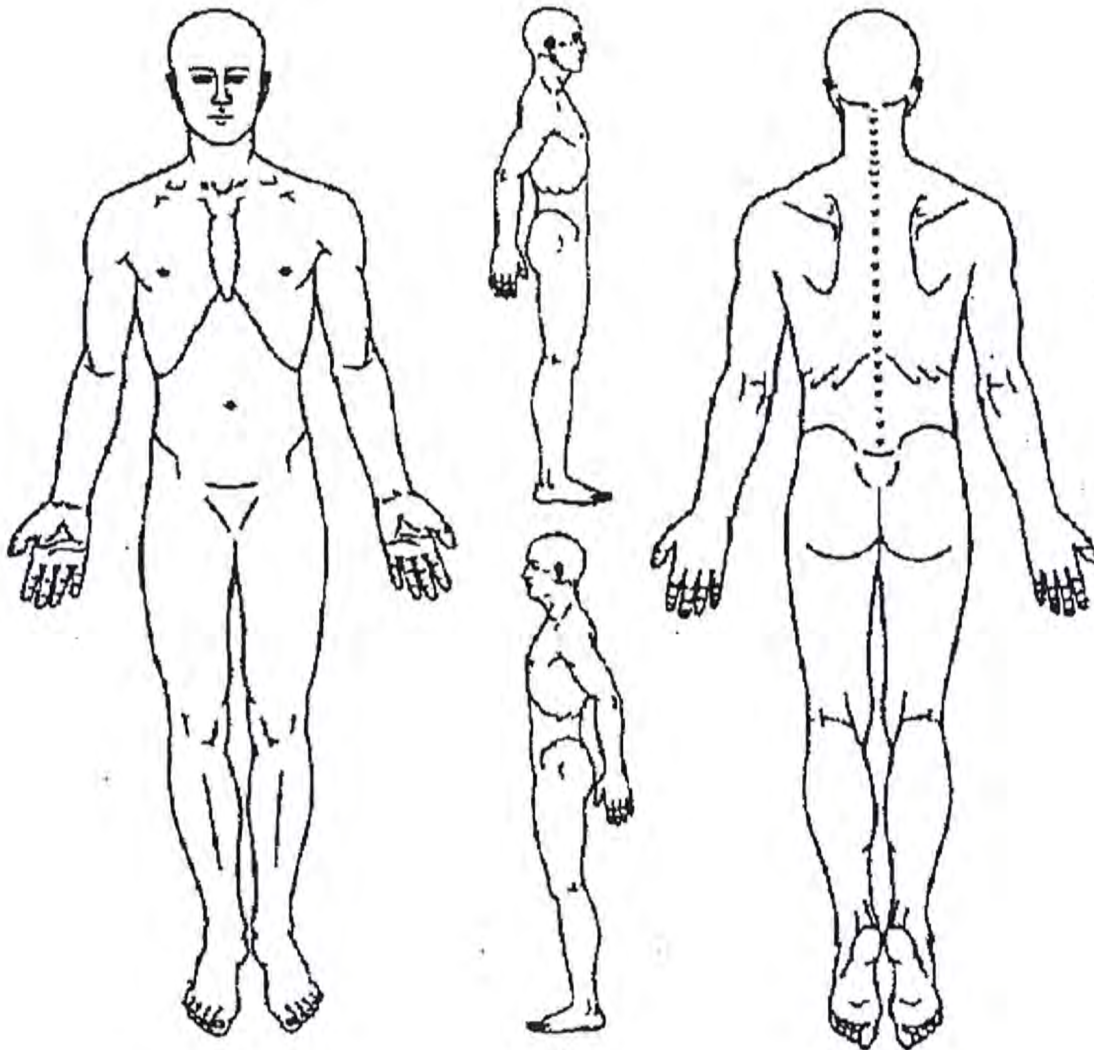
- Please place a check mark next to any of the problems you have experienced in the past 6 months.

- ☐ Fevers
- ☐ Weight gain
- ☐ Weight loss (unexplained)
- ☐ Weight loss (planned)
- ☐ Vision changes
- ☐ Trouble swallowing
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Other joint pain
- ☐ Other muscle pain
- ☐ Rashes
- ☐ Loss of coordination
- ☐ Fainting
- ☐ Headaches/Migraines
- ☐ Anxiety
- ☐ Incontinence
- ☐ Burning urination
- ☐ Difficulty urinating
- ☐ Sweats
- ☐ Fatigue
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Wheezing
- ☐ Leg cramps
- ☐ Palpitations
- ☐ Chest pain
- ☐ Heartburn
- ☐ Nausea
- ☐ Fracture
- ☐ Bone pain
- ☐ Muscle spasm
- ☐ Skin ulcers
- ☐ Hives
- ☐ Weakness
- ☐ Numbness
- ☐ Depression
- ☐ Disoriented
- ☐ Discharge
- ☐ Frequent urination
- ☐ Bleeding

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	O O O O O	^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
- - - - - -	O O O O O	^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
- - - - - -	O O O O O	^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗



NAME ______________________________ DATE __________________

No Pain |————————————————————————————| Worst Possible Pain

Please make a slash through this line as to the level of your pain.

____

Patient Signature

FIGURE 17-A

Pain Disability Questionnaire (PDQ)

Patient Name: ______________________ **Date:** ____________

Instructions: These questions ask for your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
   Work normally — *Unable to work at all*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
   Take care of myself completely — *Need help with all my personal care*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

3. Does your pain interfere with your traveling?
   Travel anywhere I like — *Only travel to see doctors*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

4. Does your pain affect your ability to sit or stand?
   No problems — *Cannot sit / stand at all*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
   No problems — *Cannot do at all*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
   No problems — *Cannot do at all*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

7. Does your pain affect your ability to walk or run?
   No problems — *Cannot walk / run at all*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

8. Has your income declined since your pain began?
   No decline — *Lost all income*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

9. Do you have to take pain medication every day to control your pain?
   No medication needed — *On pain medication throughout the day*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

10. Does your pain force you to see doctors much more often than before your pain began?
    Never see doctors — *See doctors weekly*
    0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
    No problem — *Never see them*
    0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
    No interference — *Total interference*
    0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
    Never need help — *Need help all the time*
    0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
    No depression / tension — *Severe depression / tension*
    0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social, and / or work activities?
    No problems — *Severe problems*
    0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

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Examiner

Anagnostis C, Gatchel RJ, Mayer TG. The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. Spine 2004; 29 (20): 2290-2302.