

•Have you seen any other doctor as a result of this accident? **Yes No**
Who and where? _____

•Have you lost any time from work because of this accident? **Yes No**
If yes, give dates of time lost. **From** _____ **to** _____

•BEFORE YOUR ACCIDENT, estimate your total lifting effort ability: **(FILL OUT IF THIS APPLIES TO YOUR WORK)**

- 1. How much weight? _____ Maximum _____ Average _____
- 2. Was this lifting done at work? **Yes No** Or at home or elsewhere? **Yes No**
- 3. How often did you carry this amount of weight? _____

•AFTER YOUR ACCIDENT, describe your total lifting ability: **(FILL OUT IF THIS APPLIES TO YOUR WORK)**

- 1. How much weight can you now lift without experiencing pain, discomfort or restriction of motion? _____
- 2. Did you experience this pain, discomfort or restriction of motion before your accident? **Yes No**
- 3. Are you now limited in your total lifting ability in some body position that you were previously not? **Yes No**
If so, specify position _____
- 4. What symptoms does lifting produce? _____
- 5. How long do these symptoms last? _____

•Are you presently able to (MARK ONE IN EACH CATEGORY): **(FILL OUT IF THIS APPLIES TO YOUR WORK)**

- 1. LIFT ___ Very heavy ___ lbs. ___ Heavy ___ lbs. ___ Light ___ lbs. ___ Sitting ___ lbs.
- 2. WORK ___ Very heavy ___ lbs. ___ Heavy ___ lbs. ___ Light ___ lbs. ___ Sitting ___ lbs.

•What positions can you work in with a **MINIMUM DEMAND** of physical effort? _____

- Can you perform any physical work activity? **Yes No**
- Can you perform any mental work? **Yes No**

PLEASE FILL OUT THE QUESTIONS AS ACURATLY AS POSSIBLE

•Relate your **BEFORE injury capacity (mark 'B')** and your **AFTER injury capacity (mark 'A')** for performing activities:

1. Walking	Normal _____	Limited _____	Difficult _____	Pain _____
2. Standing	Normal _____	Limited _____	Difficult _____	Pain _____
3. Sitting	Normal _____	Limited _____	Difficult _____	Pain _____
4. Bending	Normal _____	Limited _____	Difficult _____	Pain _____
5. Stooping	Normal _____	Limited _____	Difficult _____	Pain _____
6. Lifting	Normal _____	Limited _____	Difficult _____	Pain _____
7. Pushing	Normal _____	Limited _____	Difficult _____	Pain _____
8. Pulling	Normal _____	Limited _____	Difficult _____	Pain _____
9. Climbing	Normal _____	Limited _____	Difficult _____	Pain _____
10. Reaching	Normal _____	Limited _____	Difficult _____	Pain _____
11. Gripping	Normal _____	Limited _____	Difficult _____	Pain _____
12. Kneeling	Normal _____	Limited _____	Difficult _____	Pain _____
13. Balance	Normal _____	Limited _____	Difficult _____	Pain _____
14. Fatigue	Normal _____	Limited _____	Difficult _____	Pain _____

- Generally speaking, is your inability to perform the above functions due to:
pain weakness structural limitations nerves?
- Do you have normal sexual function? **Yes No**
- Are you able to take personal care of yourself, such as dressing, bathing, cleaning your house etc.? **Yes No**
Or do you require assistance? **Yes No**
- Do you feel your present condition is temporary? **Yes No** Permanent? **Yes No**

Patient's signature _____ **Date** _____