



Patient: _____ **Date:** _____

Age: _____ **Sex:** _____ **Marital Status:** _____

Referral: How did you hear about us? _____

Please list names of any one who should receive a copy of this report: _____

What are your pain concerns today? _____

EMPLOYMENT:

Is your pain work related? Yes No

Is there an open Workers' Compensation claim? Yes No

Is there legal action pending? Yes No

Job Title when injured: _____

Job Description: _____

Salary before work injury: _____ **Present income:** _____

List any other jobs or income sources at the time of our work injury: _____

Current work status: Regular Modified Not Working Part Time Full Time Same Employer
 Different Employer

Do you have an attorney? Yes- List contact info: _____ No

HISTORY OF PRESENT ILLNESS:

How long have you noticed your pain? _____ Days _____ Weeks _____ Months _____ Years

Was there any injury/event that caused your pain? Yes No (Please describe your pain below):

Where is your pain located? (Circle the area of chief complaint)

- | | |
|---|--|
| <input type="checkbox"/> Upper Back/Mid Back/Low Back | <input type="checkbox"/> Buttock/Hip/ Legs |
| <input type="checkbox"/> Shoulder/Elbow/ Hand | <input type="checkbox"/> Foot/Ankle |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Other |

Rate your usual pain (Circle number below that best applies):

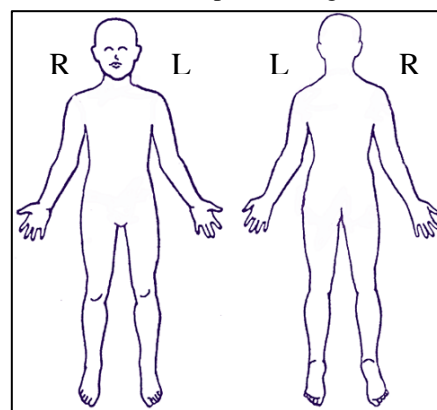
No Pain 0 1 2 3 4 5 6 7 8 9 10 The Worst Pain Imaginable

Describe your pain (Check all that apply):

- | | | | |
|---|---|--|------------------------------------|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Sharp-Shooting | <input type="checkbox"/> Tingling | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Pinprick | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Deep-pressure | <input type="checkbox"/> Tightness |
| <input type="checkbox"/> Spasms <input type="checkbox"/> Other: _____ | | | |

Where is the Pain?

(Indicate location of pain in diagram below):



What makes the pain worse? _____

What makes the pain better? _____

How does the pain limit you? _____

Patient Name: _____ DOB: _____

PAST TREATMENT:

Which of the following treatments/ evaluations have you tried for your pain? (Check all that apply):

- MRI X-Ray CT EMG Bone Scan Blood/Laboratory Epidurals
- Physical Therapy TENS Heating Pad Ice Injections Exercise Steroids
- Surgery Massage Medications Acupuncture Hypnotherapy

CURRENT MEDICATIONS:

<u>Name of Medication</u>	<u>Strength</u> (e.g. mg, mcg)	<u>Frequency</u> (e.g. once a day)	<u>Number of Pills Taken</u> <u>At One Time</u>	<u>Prescribing</u> <u>Physician</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PAST MEDICAL HISTORY (Check all that apply):

- Diabetes Arthritis Depression Osteoporosis Heart Disease High Blood Pressure Cancer
- Other: _____

ALLERGIES (Please also list reactions): _____

PAST SURGICAL HISTORY (List all surgeries below or write N/A):

<u>Surgery Type</u>	<u>Date of Surgery (Mo/Yr)</u>	<u>Surgeon</u>
_____	_____	_____
_____	_____	_____

HOSPITALIZATION (List all hospital visits below or write N/A):

<u>Reason for Most Recent Hospitalization or ER visit?</u>	<u>Date of Admission (Mo/Yr)</u>	<u>Name of Hospital</u>
_____	_____	_____
_____	_____	_____

FAMILY HISTORY (Check all that apply):

- Arthritis Diabetes Bone Disease Cancer Arteriosclerosis Other: _____

Mother: Age _____ Healthy Deceased due to _____

Father: Age _____ Healthy Deceased due to _____

SOCIAL HISTORY:

What is your highest level of education? _____

How would you describe your childhood? _____

Have you ever served in the military? Yes No

Have you ever been arrested or convicted of a crime? Yes No

Relationship Status: Are you: Single? Married? Separated? Divorced? Widowed?

How many times have you been married? _____

If married now, how long have you been married? _____

What is the job title of your spouse/ companion? _____

If you have children, please list their ages (circle the ones living with you): _____

Patient Name: _____ DOB: _____

Who do you live with? _____

List your hobbies and recreational activities before your work injury (Circle those you can no longer do):

Smoking Status: Are you a: Current Smoker? How many packs a day? _____ Former Smoker?
How many years since you smoked? _____ Never smoker?

Do you drink alcohol? Yes- How many glasses per week? _____ No

Do you use tobacco? Yes- How much per day? _____ No

Do you use recreational drugs? Yes- Please elaborate: _____ No

Have you ever abused drugs or alcohol in the past? Yes No

Have you ever been treated at a drug or alcohol rehabilitation center? Yes No

What do you hope to be doing in one year? _____

List all the dates of all work injuries and the parts of your body that were injured each time:

Body Part injured: _____ Date of Injury: _____

Body Part injured: _____ Date of Injury: _____

Body Part injured: _____ Date of Injury: _____

REVIEW OF SYSTEMS (Please circle all current symptoms only):

<u>Skin</u>	<u>Neurological</u>	<u>Eyes</u>	<u>Lymph Nodes</u>
Rash	Headaches	Visual loss	Enlargement
Easy bruising/ bleeding	Incontinence	Color blindness	Pain
Abnormal hair loss	Seizures	Glaucoma	
Nail ridging/ pitting	Paralysis	Glasses/ Contacts	
<u>Ears/ Nose/ Throat</u>	<u>Genitourinary</u>	<u>Bone/ Joint Muscles</u>	<u>Respiratory System</u>
Deafness	Blood in urine	Dislocation	Short breath
Vertigo/ Dizziness	Impotence	Fracture	Cough
Hoarseness	Painful urination	Muscles wasting	Asthma
Sinusitis	Kidney Stones	Muscle pain	Tuberculosis
Post Nasal Drip	Venereal Disease	Muscle weakness	Pneumonia
<u>Mental Status</u>	<u>Blood System</u>	<u>Endocrine System</u>	<u>Cardiovascular System</u>
Hallucinations	Anemia	Abnormal growth	Palpitations
Nervous breakdown	Bleeding	Goiter	Chest pain
Depression	Bruising	Heat/ Cold intolerance	Leg swelling
Sleep disturbances	Blood Thinners	Increased thirst	Arythmia
<u>Constitutional</u>	<u>Allergies</u>	<u>Gastrointestinal</u>	<u>General</u>
Fever/ Chills	Dermatitis	Appetite changes	Poor sleep
Weight Loss	Hay Fever	Jaundice	Poor energy
Nausea	Migraine	Hemorrhoids	Eat too much
Vomiting	Sensitivity to pollen	Irritable bowels	Eat too little
			Unhappy

OFFICE USE ONLY: Ht: _____ Wt: _____ BP: _____ HR: _____



THE EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.

Use the following scale to choose the most appropriate number for each situation:

- 0 = would never doze or sleep
- 1 = slight chance of dozing or sleeping
- 2 = moderate chance of dozing or sleeping
- 3 = high chance of dozing or sleeping

Please fill in your answers:

Situation	Chance of Dozing or Sleeping
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
Total score (add the scores up)	_____



PHQ-9 – Scoring Tally Sheet

Patient Name _____

Date _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully and check your response.

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little or no pleasure in doing things				
b. Feeling down, depressed or hopeless				
c. Trouble falling asleep, stay asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure or feeling that you have yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed; or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
TOTALS				

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

FOR CPAINMC STAFF USE ONLY:

TOTAL: _____



QUESTIONS CONCERNING ACTIVITIES OF DAILY LIVING (ADL)

Name: _____

Date: _____

Please fill out this form based on how you are currently feeling. Please fill out this form carefully and mark only one box for each question.

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

- I can look after myself normally without having extra discomfort.
- I can look after myself normally but have extra discomfort.
- It is uncomfortable to look after myself and I am slow and careful.
- I need some help but I manage most of my personal self-care.
- I need help every day in most aspects of my person self-care.
- I do not get dressed, I wash with difficulty and I stay in bed or lay down most of the day.

2. How well can you lift and carry?

- I can lift and carry heavy objects without having extra discomfort.
- I can lift and carry heavy objects but I get extra discomfort.
- I can lift and carry heavy objects only if they are conveniently positioned.
- I can only lift and carry light to medium objects if they are conveniently positioned.
- I can only lift very light objects.
- I cannot lift or carry anything at all.

3. How well can you walk?

- I am able to walk the same distance I could before my injury.
- My injury and discomfort prevents me from walking more than 1 mile.
- My injury and discomfort prevents me from walking more than 1/2 mile.
- My injury and discomfort prevents me from walking more than 1/4 mile.
- Because of my injury and discomfort I walk only a limited distance or use a cane or walker.
- Because of my injury and discomfort I am in bed most of the time or use a wheelchair.

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

- Very heavy activity
- Heavy activity
- Moderate activity
- Light activity
- Very light activity
- Extremely light to no activity

5. How well can you climb a flight of stairs?

- No difficulty (and you can easily perform the activity)
- Some difficulty (but you can still perform the activity well enough)
- A lot of difficulty (but you can still do the activity)
- Unable (you cannot do this activity or someone else helps you with it)

6. How well can you sit for 30 minutes?

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

7. How well can you sit for 2 hours?

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

8. How well can you stand or walk 30 minutes to an hour?

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

9. How well can you stand or walk for 2 hours?

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

10. How well can you reach and grasp something off a shelf at eye level?

- No difficulty (and you can easily perform the activity)
- Some difficulty (but you can still perform the activity well enough)
- A lot of difficulty (but you can still do the activity)
- Unable (you cannot do this activity or someone else helps you with it)

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

- No difficulty (and you can easily perform the activity)
- Some difficulty (but you can still perform the activity well enough)
- A lot of difficulty (but you can still do the activity)
- Unable (you cannot do this activity or someone else helps you with it)

12. Do you have any difficulty with pushing and pulling activities?

- No difficulty (and you can easily perform the activity)
- Some difficulty (but you can still perform the activity well enough)
- A lot of difficulty (but you can still do the activity)

Patient Name: _____ DOB: _____

- Unable (you cannot do this activity or someone else helps you with it)

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

- No difficulty (and you can easily perform the activity)
- Some difficulty (but you can still perform the activity well enough)
- A lot of difficulty (but you can still do the activity)
- Unable (you cannot do this activity or someone else helps you with it)

14. Do you have any difficulty with repetitive motions such as typing on a computer?

- No difficulty (and you can easily perform the activity)
- Some difficulty (but you can still perform the activity well enough)
- A lot of difficulty (but you can still do the activity)
- Unable (you cannot do this activity or someone else helps you with it)

15. Do you have any difficulty with forceful activities with your arms and hands?

- No difficulty (and you can easily perform the activity)
- Some difficulty (but you can still perform the activity well enough)
- A lot of difficulty (but you can still do the activity)
- Unable (you cannot do this activity or someone else helps you with it)

16. Do you have any difficulty with kneeling, bending or squatting?

- No difficulty (and you can easily perform the activity)
- Some difficulty (but you can still perform the activity well enough)
- A lot of difficulty (but you can still do the activity)
- Unable (you cannot do this activity or someone else helps you with it)

17. Do you have any difficulty sleeping?

- I have no trouble sleeping because of my injury and discomfort.
- My sleep is slightly disturbed (less than 1 hour sleepless) since my injury.
- My sleep is mildly disturbed (1-2 hours sleepless) since my injury.
- My sleep is moderately disturbed (2-3 hours sleepless) since my injury.
- My sleep is greatly disturbed (3-5 hours sleepless) since my injury.
- My sleep is completely disturbed (5-7 hours sleepless) since my injury.

18. In regards to sexual activity since and because of your injury?

- It is not a problem and there has not been a change because of my injury.
- It is a little less frequent because of my injury.
- It is much less frequent because of my injury.
- No sexual functioning because of my injury.

19. In regards to your pain at the moment?

- I have no pain at the moment.
- My pain is mild at the moment.
- My pain is moderate at the moment.
- My pain is severe at the moment.

Patient Name: _____ DOB: _____

- My pain is the worst imaginable at the moment.

20. In regards to your pain most of the time?

- I have no pain most of the time.
- My pain is mild most of the time.
- My pain is moderate most of the time.
- My pain is severe most of the time.
- My pain is the worst imaginable most of the time.

21. How much do your injury and/or pain interfere with your ability to travel?

- None
- Some or a little of the time
- A lot or most of the time
- All of the time – I can't travel

22. How much do your injury and/or pain interfere with your ability to engage in social activities?

- None
- Some or a little of the time
- A lot or most of the time
- All of the time – I can't engage in social activities

23. How much do your injury and/or pain interfere with your ability to engage in recreational activities?

- None
- Some or a little of the time
- A lot or most of the time
- All of the time – I can't engage in recreational activities

24. How much do your injury and/or pain interfere with concentrating or thinking?

- None
- Some or a little of the time
- A lot or most of the time
- All of the time – I can't concentrate or think very clearly

25. How much has your injury and/or pain caused emotional distress with depression or anxiety?

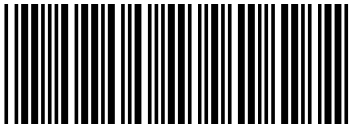
- None (no depression or anxiety from the injury or discomfort)
- Some or a little of the time (mild depression or anxiety from the injury or discomfort)
- A lot or most of the time (moderate depression or anxiety from the injury or discomfort)
- All of the time (severe depression or anxiety from the injury or discomfort)

Patient Name: _____ DOB: _____

Work & Functional Capacity Activity Estimation Summary

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

ACTIVITY (Hours per Day)	NEVER 0 hours	SOME <1 hour	OCCASIONALLY 1-3 hours	FREQUENTLY 3-6 hours	CONSTANTLY 6-8 hours+
Repetitive neck motions					
Static neck posturing					
Bending / Twisting (waist)					
Squatting & kneeling					
Sitting					
Standing					
Walking					
Climbing stairs					
Climbing ladders					
Walking over uneven ground					
Working at heights					
Working around moving machinery					
Repetitive use of upper extremity (right)					
Repetitive use of upper extremity (left)					
Grasping / Gripping (right hand)					
Grasping / Gripping (left hand)					
Forceful use of upper extremity (right)					
Forceful use of upper extremity (left)					
Fine manipulation (right hand)					
Fine manipulation (left hand)					
Pushing & pulling (right) – in pounds					
Pushing & pulling (left) – in pounds					
Reaching (at shoulder level)					
Reaching (above shoulder level)					
Lifting / Carrying – in pounds					



STATE OF CALIFORNIA Division of
Workers' Compensation Disability
Evaluation Unit



EMPLOYEE'S DISABILITY QUESTIONNAIRE

DEU Use Only

This form will aid the doctor in determining your permanent impairment or disability. Please complete this form and give it to the physician who will be performing the evaluation. The doctor will include this form with his or her report and submit it to the Disability Evaluation Unit, with a copy to you and your claims administrator.

Employee

First Name

MI

Last Name

SSN (Numbers Only)

Street Address 1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address 2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Date of Birth

MM/DD/YYYY

Date of Injury

MM/DD/YYYY

Employer

Nature of Employers Business

Claim Number 1

Claim Number 2 _____

Claim Number 3 _____

Claim Number 4 _____

Claim Number 5 _____

PLEASE ANSWER THE FOLLOWING QUESTIONS FULLY:

How was your evaluating doctor selected? (check one)

From a list of doctors provided by the State of California, Division of Workers' Compensation.

Other (explain) _____

What is the name of the doctor who will be doing the evaluation? _____

When is your examination scheduled? _____

What were your job duties at the time of your injury?

What is the disability resulting from your injury?

How does this injury affect you in your work?

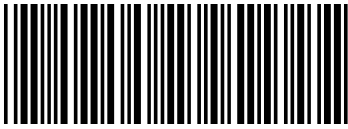
Have you ever had a disability as a result of another injury or illness? _____

If so, when? _____

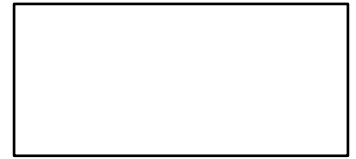
Please describe the disability?

Date _____
MM/DD/YYYY

Signature _____



State of California
Division of Workers' Compensation
Disability Evaluation Unit



DEU Use Only

REQUEST FOR SUMMARY RATING DETERMINATION
of Qualified Medical Evaluator's Report



INSTRUCTIONS TO THE CLAIMS ADMINISTRATOR:

1. Use this form if employee is unrepresented and has not filed an application for adjudication.
2. Complete this form and forward it along with a complete copy of all medical reports and medical records concerning this case to the physician scheduled to evaluate the existence and extent of permanent impairment or disability.
3. Send the EMPLOYEE'S DISABILITY QUESTIONNAIRE, DEU FORM 100 to the employee in time for the medical evaluation.
4. **This form must be served on the employee prior to the evaluation. Be sure to complete the proof of service.**

INSTRUCTIONS TO THE PHYSICIAN:

1. If the employee is unrepresented, review and comment upon the Employee's Disability Questionnaire, (DEU Form 100), in your report. (If the employee does not have a completed Form 100 at the time of the appointment, please provide the form to the employee.)
2. Submit your completed medical evaluation and, if the employee is unrepresented, the DEU Form 100, to the Disability Evaluation Unit district office listed below. **PLEASE USE THIS FORM AS A COVER SHEET FOR SUBMISSION TO THE DISABILITY EVALUATION UNIT.**
3. Serve a copy of your report and the Form 100 upon the claims administrator and the employee.

Date of first medical report indicating the existence of permanent impairment or disability: _____
MM/DD/YYYY

Last date for which temporary disability indemnity was paid: _____
MM/DD/YYYY

Submit To: Disability Evaluation Unit

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State CA Zip Code _____

Physician _____

Exam Date _____
MM/DD/YYYY



Claims Administrator



Company Name

Street Address1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Claim Number 1

Claim Number 2

Claim Number 3

Claim Number 4

Claim Number 5

Phone No. _____

Adjustor _____

Employer _____

Employee

First Name _____

MI _____

Last Name _____

Street Address 1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address 2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)



City _____ State _____ Zip Code _____

Date of Injury _____ Date of Birth _____
MM/DD/YYYY MM/DD/YYYY

SSN (Numbers Only) _____

Case No (if any) _____

OCCUPATION _____

(Please attach job description or job analysis, if available)

WEEKLY GROSS EARNINGS _____

(Attach a wage statement/DLSR 5020 if earnings are less than maximum. Include the value of additional advantages provided such as meals, lodging, etc. If earnings are irregular or for less than 30 hours per week, include a detailed description of all earnings of the employee from all sources, including other employers, for one year prior to the date of injury. Benefits will be calculated at MAXIMUM RATE unless a complete and detailed statement of earnings is attached.)



PROOF OF SERVICE BY MAIL

On _____, I served a copy of this Request for Summary Rating Determination on

Name of Employee _____

Address _____

City _____ State _____ Zip _____

by placing a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature





COMPREHENSIVE
Pain Management Center
Defining Excellence in Pain Management

Annu H. Navani, M.D., Q.M.E. & Associates
Board Certified in Pain Management & Anesthesia
Ph: 408.356.5292
Fax: 408.356.5307
www.cpainmc.com

Directions to Comprehensive Pain Management Center

Located at:
3425 S. Bascom Ave, Ste. 200
Campbell CA 95008

San Francisco / North Bay

Take Hwy 101 South or Hwy 280 South to 85 South toward Gilroy
Take the Los Gatos Blvd / Bascom Ave exit
Turn left on S. Bascom Ave
The Medical Center will be on the left approximately $\frac{3}{4}$ mile up

Oakland / East Bay

Take Hwy 880 South to Hwy 17 (880 becomes 17)
Take the Camden Ave / San Thomas Expwy exit
Turn left onto Camden Ave
Turn right onto S. Bascom Ave
The Medical Center will be on the right approximately less than $\frac{1}{4}$ mile up

Concord

Take Hwy 680 South to San Jose
Hwy 680 becomes Hwy 280 in San Jose
Continue on Hwy 280 North to Hwy 17/880
Exit Hwy 17 South towards Santa Cruz
Take the Camden Ave / San Thomas Expwy exit
Turn left onto Camden Ave
Turn right onto S. Bascom Ave
The Medical Center will be on the right approximately less than $\frac{1}{4}$ mile up

Gilroy / Salinas Areas

Take Hwy 101 North to 85 North towards Mountain View
Take the Bascom Ave exit towards Los Gatos Blvd
Turn right onto S. Bascom Ave
The Medical Center will be on the left approximately $\frac{3}{4}$ mile up