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CALIFORNIA STATE QUALIFIED MEDICAL EXAMINER
SF, Richmond, Petaluma, Sacramento and Arcata, California

Date of Examination	Location of Examination
Name	Social Security Number
Address	Age Height and Weight
Telephone	Date of Birth
Employer Name and Location ON Date of Injury	Which hand do you use to write with?
Injured Body Part (s):	<u>Date of Injury:</u>
Referring Physician (Last MD you saw)	<u>Do you have an attorney? Name, address and Tel.</u>

History of Present Illness

9. Describe the event(s) that took place that caused this injury? If an accident explain details. If from repetitive motion, explain what body part first was a problem, when and why you feel it is work related.
 (Use the back of this sheet for more room.)

10. Describe when and what kind of treatment that you received immediately after the accident?
 Who was the first MD you saw? Where? and When? Have you seen specialists?
 Give dates and practitioner's name. Have you had any tests? MRIs? EMGs? Epidural injections, etc? What MD has most recently seen you? When did you last have physical therapy? (Please use other side if necessary)

Occupational History	
11. What was the name and city and state of the business where this event occurred? Please list the <u>date of hire</u>. <u>Do you still work for this company?</u> New Employer? What days and hours do you work ?	
12. What is/ was your job title and job description when this injury occurred? What are/ were the routine tasks of the job? If not the same, what are the routine tasks of your job now? <u>How many pounds lifting and how often?</u> Did you do bending, climbing, reaching?	
13. Were you engaged in the routine tasks of your job when this injury took place?	
14. Do you have a second job? What are the hours? Job description?	
15. List your prior work history for 5 years. Years, name of company, job title, brief job description. Did you have worker injury claims at these jobs?	
Past Medical History	
17. Have you had prior injuries to this body part <i>or area of your body</i> ? Please describe. Include prior surgeries & dates & treatment. List all other Medical Conditions. Family history?	
18. If you answered “yes” to the above question, had your problem resolved completely before the injury in question occurred? If not, describe your condition prior to the injury.	
19. Current Medications (For ALL Conditions)	
21. Allergies to medications?	22. Do you use alcohol, smoke, or recreational drugs?

Current Complaints/Status	
What are your current complaints? Do you have pain? If yes, describe what is the quality of pain, burning? Aching? Throbbing? What number 0-10 best describes your pain? How frequent is your pain?	25. Do you have pain at rest? In a seated position, standing position or while walking? Problems with sleeping? Daytime sleepiness? Headaches? Sexual dysfunction? Gastrointestinal distress? (Use reverse)
26. What activities make the pain worse?	27. What makes the pain better?
Current Activities	
28. What is the heaviest thing you lifted last week?	29. Do you drive? Did you drive today?
30. Do you have children at home? What ages? Marriage status?	31. Do you receive disability compensation?
32. List hobbies & daily activities?	
33. List your present treatment program? Include name/type of practitioners, how often per month? Physical therapy? Acupuncture? Chiropractor?	
34. What is your current job status? Please circle correct answer. a. Working normal duty b. Modified duty c. Out of work because no modified duty exists d. Totally disabled Please list dates that you were not working up until the present.	
35. Are you receiving any job retraining? Please describe.	
36. DO you have an attorney? Please list name, address and phone number.	