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

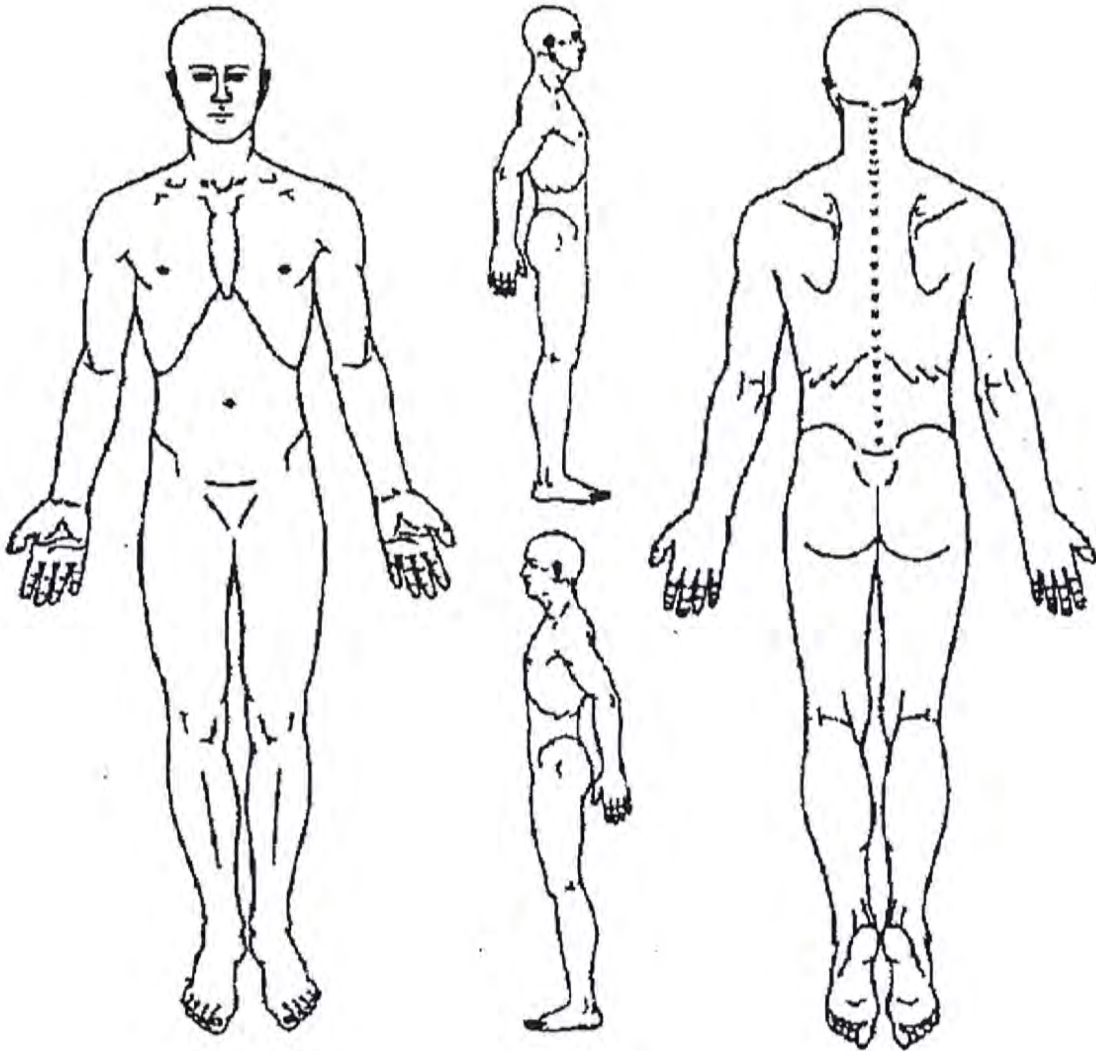
- Please place a check mark next to any of the problems you have experienced in the past 6 months.

- ☐ 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

Lower Limb Questionnaire

Instructions

Please answer the following questions for the lower limb being treated or followed up. If it is BOTH lower limbs, please answer the questions for your **worse** side. All questions are about how you have felt, on average, during the **past week.** If you are being treated for an injury that happened less than one week ago, please answer for the period since your injury.

1. During the **past week**, how **stiff** was your lower limb? (Circle one response.)

1 Not at all 2 Mildly 3 Moderately 4 Very 5 Extremely

2. During the **past week**, how **swollen** was your lower limb? (Circle one response.)

1 Not at all 2 Mildly 3 Moderately 4 Very 5 Extremely

During the **past week**, please tell us about how painful your lower limb was during the following activities. (Circle ONE response on each line that best describes your average ability.)

	Not painful	Mildly painful	Moderately painful	Very painful	Extremely painful	Could not do because of lower limb pain	Could not do for other reasons
3. Walking on **flat** surfaces?	1	2	3	4	5	6	7
4. Going up or down stairs?	1	2	3	4	5	6	7
5. Lying in bed at night?	1	2	3	4	5	6	7

6. Which of the following statements **best** describes your ability to get around most of the time during the **past week**? (Circle one response.)

1 I did not need support or assistance at all.
2 I mostly walked without support or assistance.
3 I mostly used one cane or crutch to help me get around
4 I mostly used two canes, two crutches or a walker to help me get around.
5 I used a wheelchair.
6 I mostly used other supports or someone else had to help me get around.
7 I was unable to get around at all.

7. How difficult was it for you to put on or take off socks/stockings during the **past week**? (Circle one response.)

1 Not at all difficult 2 A little bit difficult 3 Moderately difficult 4 Very difficult 5 Extremely difficult 6 Cannot do it at all