

**CONFIDENTIAL**  
**CLIENT'S MEDICAL EXAMINATION REPORT TO ATTORNEY**

Name \_\_\_\_\_

File # \_\_\_\_\_

Please be sure to fill out this form in detail. If additional room is needed use a separate sheet of paper and identify the answer by number. Do not write on the back of the report.

Date of Exam \_\_\_\_\_ Time of Appointment \_\_\_\_\_

Name of Doctor \_\_\_\_\_

Date of most recent examination prior to this \_\_\_\_\_

Performed by \_\_\_\_\_

Round trip mileage \_\_\_\_\_ Parking Cost (with receipt) \_\_\_\_\_

1. Time you arrived \_\_\_\_\_ Time you left \_\_\_\_\_

2. How long before you saw the doctor \_\_\_\_\_

3. How much time spent asking you questions \_\_\_\_\_

4. How much time spent examining you \_\_\_\_\_

5. Did you miss any time from work \_\_\_\_\_

If so, name of employer \_\_\_\_\_

Rate of pay \_\_\_\_\_ # of hours missed \_\_\_\_\_

If possible, please attach a pay stub documenting the above.

**Please circle the appropriate response or responses.**

6. My medical **HISTORY** was taken by:

- a. the doctor      b. the nurse      c. part by both      d. other

7. The method by which my medical **HISTORY** was taken:

- a. shorthand      b. written out      c. on a typewriter      d. by recorder

8. Was your medical history read back to you:    yes    no

9. Were you able to fully answer all questions and explain your injuries and complaints:    yes    no

If no, what did you want to say? \_\_\_\_\_

10. Did the doctor touch a pin, feather, or other object to your:

- a. face      b. arms or hands      c. legs or feet

11. If so, what object was used and describe how? \_\_\_\_\_  
\_\_\_\_\_
12. Did you notice any numbness or have difficulty feeling these tests? yes no
13. If yes, explain those feelings: \_\_\_\_\_  
\_\_\_\_\_
14. Did the doctor check your reflexes in any of the following:  
a. elbow b. ankle c. wrist d. knee e. back
15. Were you instructed to stand with your eyes closed: yes no
16. Were you instructed to stand on each foot separately: yes no
17. If you had any difficulty doing this, explain \_\_\_\_\_
18. Did the doctor test your grip either by: a. hand b. instrument
19. Did the doctor measure your: a. arms b. thighs c. calves d. leg length  
If so, were you measured carefully: yes no
20. Did the doctor press on your: a. neck b. back c. legs  
If this caused pain, please explain \_\_\_\_\_
21. Did the doctor ask you to bend your: a. neck b. back c. arms d. legs  
If this caused you pain please explain \_\_\_\_\_  
Were you able to bend normally \_\_\_\_\_
22. Did the doctor turn your head in different directions: yes no  
If this caused you pain please explain \_\_\_\_\_  
Explain if the doctor was able to turn your head and neck normally \_\_\_\_\_  
\_\_\_\_\_
23. Were you asked to lay down and raise your leg straight up: yes no  
If this caused you pain please explain \_\_\_\_\_  
Explain if the doctor was able to raise your leg normally \_\_\_\_\_
24. Were you asked to bend over and try to touch the floor: yes no  
If this caused you pain please explain \_\_\_\_\_

How close to the floor could you reach \_\_\_\_\_

25. Which of the following examinations or tests did the doctor perform:

a. blood pressure      b. blood test      c. temperature      c. urine

26. Were your eyes examined:    yes    no

Looked into with flashlight:    yes    no

Asked to follow moving object:    yes    no

27. Were your ears examined:    yes    no

Was a hearing test done:    yes    no

28. Describe any examination performed that is not mentioned above \_\_\_\_\_

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### **BEFORE THE EXAMINATION**

29. Describe all activities you engaged in today prior to the examination \_\_\_\_\_

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30. Did you receive any treatment or take any medication prior to this examination \_\_\_\_\_

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31. Have you taken or will you take any medication subsequent to this examination \_\_\_\_\_

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32. Following this examination do you feel your condition is worse in any way and how \_\_\_\_\_

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33. Do you feel that anything unusual occurred during the examination, and if so describe \_\_\_\_\_

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34. Please list any comments made by the doctor, word for word to your best recollection, regarding

Your present condition

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Your lawsuit or lawyer

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Other doctors or other treatments

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The cause of your complaints

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35. Did the doctor make any recommendations or suggestions to you? \_\_\_\_\_

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36. List as many question as possible that the doctor asked you and the responses that you gave

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Is there anything else that occurred during the IME that your doctor or your lawyer should know about?

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Client's signature

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Date

\* Please recheck the questionnaire and make you sure have filled it out completely. This information is absolutely essential to the successful handling of your case.