Medical Functional Assessments
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Objective Functional Capacity Evaluations · Post-Offer/Pre-Placement Evaluations
Ergonomic Analysis · Fitness for Duty Testing · State and National Network

CONSENT AND RELEASE FORM

I, the undersigned, do hereby acknowledge:

- My consent to Functional Testing, (also known as a Functional Capacity Assessment, Functional Capacity Evaluation or Work Capacity Evaluation) consisting of the physical exercise measures as explained to me.
- My understanding that a qualified examiner trained to administer the Functional Determination of Injury will conduct the tests.
- My understanding that the test results will be used to compare my current physical abilities with the physical demands associated with my regular / modified employment or activities of daily living.
- My understanding that during and following the physical test, I may experience an increase in my symptoms, or symptoms associated with fatigue.
- My obligation to immediately inform the examiner of any pain, fatigue or discomfort that I may experience during and immediately following the testing.
- My understanding that I may interrupt the testing at any time to ask questions, request further explanation or information before continuing.
- My understanding that testing may be terminated by the examiner upon observation of abnormal responses or safety concerns.
- My understanding that Medical Functional Assessments is an independent assessment center and is not employed by the insurance company / employer or any other facility.
- I authorize Medical Functional Assessments to release information documented during the course of the evaluation to my insurer, employer, attorney or medical provider. The report will not be released to any third party unless specified by the referral source.
- I hereby release Medical Functional Assessments or its agents, officers and employees from any liability with respect to any injury that I may suffer during the administration of the functional evaluation except where the injury is caused by the negligence of Medical Functional Assessments, or it's agent, officers and employees acting within the scope of their duties.

_____ _____

Patient's Signature Date Signature of Witness Date

Medical Functional Assessments

Physical Screening Questionnaire

Common Sense is your best guide in answering these few questions. Please read them carefully and circle the YES or NO opposite the question.

1. Has your doctor ever told you that you have heart or lung problems? YES NO

2. Have you ever had any heart related problems? YES NO

3. Do you frequently feel any chest discomfort or pain? YES NO

4. Do you often faint or have spells of severe dizziness? YES NO

5. Has your doctor ever told you that you have high blood pressure, or have you ever had high blood pressure in the past, or are you presently taking medication for blood pressure? YES NO

6. Are you aware of any bone, back or joint problems that may be, or could be aggravated by exercise? (e.g. Arthritis) YES NO

7. Have you ever had an episode of exercise-induced asthma, that is, severe wheezing, coughing or severe shortness of breath brought on by exercise, or do you ever have unaccustomed shortness of breath at rest or with mild exercise? YES NO

8. Do you ever have episodes of labored or difficult breathing during the night where you have to sit up to breathe? YES NO

9. Have you ever been told by a doctor that you have diabetes? YES NO

10. Are you over age 65 and not involved in regular exercise? YES NO

11. Is there a good reason not mentioned here why you should not engage in exercise even if you wanted to? (e.g. surgery during the past six months) YES NO

12. Are you pregnant? YES NO

Comments: _____

_____

_____

I hereby certify that the above information is correct.

_____ _____

Participant's Signature Date

Any "YES" response concerning cardiovascular, pulmonary or metabolic problems may not engage in any fitness test or exercise program until a medical clearance form is completed and signed by an appropriate physician.

Medical Clearance Form

I hereby certify that, to the best of my knowledge, this person examined has no contraindications to participation in a sub-maximal exercise profile, musculoskeletal rehabilitative, and/or progressive fitness program.

List Any Limitations or Precautions: _____

_____

_____

_____ _____

Signature of Physician Type or Print Name

_____ _____

Phone Date

Visual Pain Rating Scale & Pain Diagram

Name: _____ **Date:** _____

Make a mark (x) along the line which you think represents your current level of pain in your major area of injury, somewhere between "NO PAIN AT ALL" and "EXCRUCIATING PAIN"

NO PAIN AT ALL **EXCRUCIATING PAIN**

Please describe your pain: (check all that apply)

PINS & NEEDLES ☐
BURNING ☐
STABBING ☐
ACHE ☐
OTHER:

DESCRIBE YOUR PAIN

DALLAS PAIN QUESTIONNAIRE

Please read:
This questionnaire has been designed to give the doctor information as to how your pain has affected your life. Be sure that these are your answers. Do not ask someone else to fill out the questionnaire for you. Please click on the line in the position that expresses your thoughts from 0 to 100% in each section.

Name: _____

Date: _____

SECTION I: PAIN AND INTENSITY

To what degree do you rely on pain medications or pain relieving substances for you to be comfortable?

NONE — SOME — ALL THE TIME

0%(* * * * *)100%

SECTION II: PERSONAL CARE

How much does pain interfere with your personal care (getting out of bed, teeth brushing, dressing, etc)?

NONE (NO PAIN) — SOME — I CANNOT GET OUT OF BED

0%(* * * * *)100%

SECTION III: LIFTING

How much limitation do you notice in lifting?

NONE (I CAN LIFT AS I DID) — SOME — I CANNOT LIFT ANYTHING

0%(* * * * *)100%

SECTION IV: WALKING

Compared to how far you could walk before your injury or back trouble, how much does pain restrict your walking now?

I CAN WALK THE SAME — ALMOST THE SAME — VERY LITTLE — I CANNOT WALK

0%(* * * * *)100%

SECTION V: SITTING

Back pain limits my sitting in a chair to:

NONE, PAIN SAME AS BEFORE — SOME — I CANNOT SIT AT ALL

0%(* * * * *)100%

SECTION VI: STANDING

How much does your pain interfere with your tolerance to stand for long periods?

NONE, SAME AS BEFORE — SOME — I CANNOT STAND

0%(* * * * *)100%

SECTION VII: SLEEPING

How much does pain interfere with your sleeping

NONE, SAME AS BEFORE — SOME — I CANNOT SLEEP AT ALL

0%(* * *)100%

SECTION VIII: SOCIAL LIFE

How much does pain interfere with your social life (dancing, games, going out, eating with friends, etc)?

NONE SAME AS BEFORE — SOME — NO ACTIVITIES TOTAL LOSS

0%(* * * * * * *)100%

SECTION IX: TRAVELING

How much does pain interfere with traveling in a car?

NONE SAME AS BEFORE — SOME — I CANNOT TRAVEL

0%(* * * * * *)100%

SECTION X: VOCATIONAL

How much does pain interfere with your job?

NONE, NO INTERFERENCES — SOME — I CANNOT WORK

0%(* * * * * * *)100%

SECTION XI: ANXIETY/MOOD

How much control do you feel that you have over demands made on you?

(NO CHANGE) TOTAL — SOME — NONE

0%(* * * * * *)100%

SECTION XII: EMOTIONAL CONTROL

How much control do you feel you have over your emotions?

(NO CHANGE) TOTAL — SOME — NONE

0%(* * * * * * *)100%

SECTION XIII: DEPRESSION

How depressed have you been since the onset of pain?

NOT DEPRESSED SIGNIFICANTLY — OVERWHELMED BY DEPRESSION

0%(* * * * * * *)100%

SECTION XIV: INTERPERSONAL RELATIONSHIPS

How much do you think your pain has changed your relationships with others?

NOT CHANGED — SOME — DRASTICALLY CHANGED

0%(* * * * * * *)100%

SECTION XV: SOCIAL SUPPORT

How much support do you need from others to help you during this onset of pain (taking over chores, fixing meals, etc

NONE NEEDED SOME ALL THE TIME

0%(* * * * * *)100%

SECTION XVI: PUNISHING RESPONSE

How much do you think others express irritation, frustration or anger toward you because of your pain?

NONE SOME ALL THE TIME

0%(* * * * * * *)100%

Oswestry Low Back Pain Disability Questionnaire

Date: _____

Please read:
This questionnaire has been designed to give the doctor/clinician information as to how your back pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the ONE sentence which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the sentence which most closely describes your problem.

Name: _____

Section 1 - Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain killers.
- ☐ The pain is bad but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain and I do not use them.

Section 2 - Personal Care (Washing, Dressing, etc)
- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3 - Lifting
- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift only very light weights
- ☐ I cannot lift or carry anything at all

Section 4 - Walking
- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than 1 mile
- ☐ Pain prevents me walking more than 1/2 mile
- ☐ Pain prevents me walking more than 1/4 mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

Section 5 - Sitting
- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me from sitting more than 1 hour
- ☐ Pain prevents me from sitting more than 1/2 hour
- ☐ Pain prevents me from sitting more than 10 mins
- ☐ Pain prevents me from sitting at all

Section 6 - Standing
- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing more than 30 mins
- ☐ Pain prevents me from standing more than 10 mins
- ☐ Pain prevents me from standing at all

Section 7 - Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than six hours sleep.
- ☐ Even when I take tablets I have less than four hours sleep.
- ☐ Even when I take tablets I have less than two hours sleep.
- ☐ Pain prevents me from sleeping at all

Section 8 - Sex Life
- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9 - Social Life
- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant affect on my social life apart from limiting my more energetic interests, eg. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10 - Travelling
- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from travelling except to the doctor or hospital

Neck Disability Index

Date: _____

This questionnaire has been designed to provide information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the ONE sentence which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the sentence which most closely describes your problem.

Name: _____

Section 1 - Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2 - Personal Care (Washing, Dressing, etc)

- I can look after myself normally without extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Section 4 - Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

Section 5 - Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Section 6 - Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty concentrating when I want to.
- I cannot concentrate at all.

Section 7 - Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

Section 8 - Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

Section 9 - Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is mildly disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-5 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 - Recreation

- I am able to engage in all my recreational activities with no neck pain at all.
- I am able to engage in all my recreational activities with some pain in my neck.
- I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I can't do any recreational activities at all.

DESCRIPTION OF JOB DEMANDS

Instructions: Please complete this form to the best of your ability. If possible, have your employer or the employer's representative complete this form with you to ensure accuracy. The purpose of this form is to better understand the job demands required by you the employee prior to being injured. Your responses will influence testing protocols and procedures. Please answer as accurately as possible.		
Employee Name:	**Claim #:**	
Employer Name and Address:		
Job Title:	**Hours worked / day:**	**Hours worked / week:**
Briefly Describe Job Duties:		

- In the Table below check the frequency box which the task is being performed on a daily basis. The percentages indicate the percent of the day that task is performed on an average day.

Task	**Frequency Performed per workday**				
	None	**Rare** <10%	**Occasional** 10-33%	**Frequent** 34-66%	**Constant** >67%
Sitting					
Standing					
Walking					
Bending at the Waist					
Bending at the Neck					
Twisting at the Waist					
Twisting of the Neck					
Squatting/ Crouching					
Kneeling					
Crawling					
Climbing					
Repetitive Hand Use					
Light Grasping					
Power Grasping					
Fine Manipulation					
Reaching - Overhead					
Reaching – Waist to Shoulder					
Reaching – Below Waist					

Rare = the task is performed no longer than 20 minutes /day. *Occasional* = the task is performed greater than 1 hr/day but less than 3 hrs per day. *Frequent* = the task is performed greater than 3 hours / day, but less than 6 hours / day. *Constant* = the task is performed for more than 6 hours/ 8 hr work day.

- In the Table below check the frequency box which your job requires you to lift, carrying, pushing and pulling. The percentages indicate the percent of the day that task is performed on an average day.

Weight or Force		**Frequency Performed per workday**				
		None	**Rare** <10%	**Occasional** 10-33%	**Frequent** 34-66%	**Constant** >67%
Lifting	**0-10 lbs**					
Lifting	**11-25 lbs**					
Lifting	**26-50 lbs**					
Lifting	**51-100 lbs**					
Lifting	**100+ lbs**					
Carrying	**0-10 lbs**					
Carrying	**11-25 lbs**					
Carrying	**26-50 lbs**					
Carrying	**51-100 lbs**					
Carrying	**100+ lbs**					
Push/Pull	**0-10 lbs**					
Push/Pull	**11-25 lbs**					
Push/Pull	**26-50 lbs**					
Push/Pull	**51-100 lbs**					
Push/Pull	**100+ lbs**					

- What is the heaviest object you must lift/carry? _____
- How high and how low do you need to lift the object? _____
- What type of object are you pushing or pulling? _____

Circle the answer which describes your job:

Does your job require you to drive cars, trucks, forklifts or other equipment? Yes No
Do you work around equipment? Yes No
Do you walk on uneven ground? Yes No
Is there excessive noise? Yes No
Is there excessive heat, cold or humidity? Yes No
Are you exposed to dust, chemicals or fumes? Yes No
Do you work at heights? Yes No

Please provide additional comments below:

_____ _____

Employee signature Employer Signature (if applicable)