

Dear Sir/Madam,

Following this page, you will find our intake form, called a Personal History Questionnaire.

Please take the time to fill out all pages carefully and completely. Your attention to detail is important because this information contributes to a thorough and accurate Life Care Plan and/or Vocational Evaluation reports. These reports will be presented in court if your case goes to trial.

Note that there is a blank area at the end of this document should you require additional space to answer any of the questions in this form. For example, there are four spaces for your medications. If you take more than four, use the space at the end of this form to add information for the fifth and additional medications.

This form must be signed and dated on the final page. If you have questions regarding the form, we would be happy to assist you. Please do not hesitate to contact our office by phone or email.

Thank you,

Lizette Mendoza

Lizette Mendoza
Life Care Plan Administrator

PERSONAL HISTORY QUESTIONNAIRE

IDENTIFYING INFORMATION

Name		Gender	
DOB:		Country of birth	
Ethnicity		Year Immigrated to US	
Driver's License State		Primary Language	
Cell Phone #		Other Languages	
Present Address			
Current Height/Weight		Pre-injury weight	
Email Address		Secondary Phone	
Military (Rank/Years)			
Date of Injury/Type			

FAMILY INFORMATION

Marital Status		Current Partner Name	
Prior Spouse Name		Prior Spouse Name	
Child's Name		Child's DOB	
Other Parent Name		Resides With You?	
Child's Name		Child's DOB	
Other Parent Name		Resides With You?	
Child's Name		Child's DOB	
Other Parent Name		Resides With You?	

MEDICAL AND TREATMENT INFORMATION

List any medical problems or conditions your doctors have diagnosed as a result of the injury in question

List any **prior accidents** or **pre-existing medical problems** or conditions that predate the injury in question

List your **current treating** and **evaluating physicians** related to the injury or medical condition(s) in question

Name	Medical Specialty	Phone	Frequency of Treatment

List your current prescribed or over-the-counter medications **related to the injury** or condition in question

Name	Purpose	Frequency Taken	Strength
<i>Ex: Oxycodone</i>	<i>Ex: Pain</i>	<i>2 tabs, 2x/Day</i>	<i>5-325mg</i>

EXERCISE AND HEALTH

Did you exercise?		If yes, what intensity?	
How often per week?		Did or do you exercise?	
Do you use tobacco?		If yes, which products?	
How many per day?		For how many years?	
Year quit (if applicable)?			
Sexually active?		Trying for pregnancy?	
Sexual dysfunction?		If yes, which type?	
Do you use a cane or walker?			
Do you use any braces or orthotics such as a knee brace or lumbar belt?			
Since the accident, have you fallen in your home or in the community?			

LIVING SITUATION INFORMATION

List the people who reside in your home, or anyone who comes to help you in your home

Name	Relationship	Age
<i>Ex: John Doe</i>	<i>Neighbor/Friend/Home Attendant</i>	<i>30</i>

EDUCATION INFORMATION (SUBMIT RESUME INSTEAD, IF APPLICABLE)

Did you graduate high school?		If yes, which HS/Year?	
If not, what is the last grade completed?		Did you obtain a GED?	
Special coursework or classes?			
Classes to learn English?			
College/Postsecondary Education and Training			
College		Degree obtained/Date	
Major		Minor (if applicable)	
# of semesters completed		Grades (average?)	
College		Degree obtained/Date	
Major		Minor (if applicable)	
# of semesters completed		Grades (average?)	
College		Degree obtained/Date	
Major		Minor (if applicable)	
# of semesters completed		Grades (average?)	
College		Degree obtained/Date	
Major		Minor (if applicable)	
# of semesters completed		Grades (average?)	

EMPLOYMENT INFORMATION (SUBMIT RESUME INSTEAD, IF APPLICABLE)

Job Title		Employer City/State	
Employer Name		Start/End Date	
Starting Salary		Ending Salary	
Responsibilities			

Job Title		Employer City/State	
Employer Name		Start/End Date	
Starting Salary		Ending Salary	
Responsibilities			

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Starting Salary		Ending Salary	
Responsibilities			

Job Title		Employer City/State	
Employer Name		Start/End Date	
Starting Salary		Ending Salary	
Responsibilities			

HOUSEHOLD ACTIVITIES

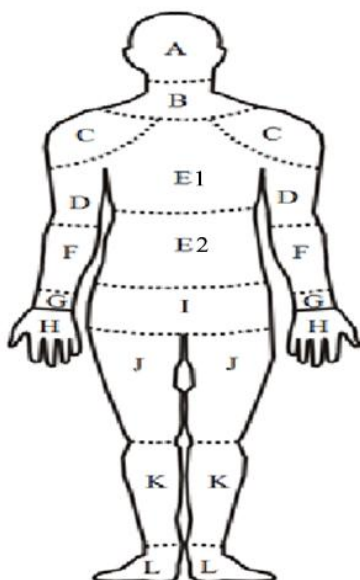
Before being injured, I did this independently	Now, I...					
	On Occasion	Frequently	Did not do this	Can still do this independently	Can do this in pain/less often	Need help/ Cannot Do
Rising from bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting/standing from toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet hygiene (wiping)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Entering/exiting shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing (socks, shoes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing (pants, skirt)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing (fine dexterity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing (upper body)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing breakfast/lunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing full dinner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opening jars/containers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using hands/fork to feed myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping for groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unloading groceries from vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Putting groceries away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running errands (bank, mail)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dusting/wiping countertops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loading/unloading dishwasher	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweeping/vacuuming/mopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning bathroom/bathtub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking out trash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundrying clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mowing lawn (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Raking leaves (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoveling snow (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning gutters (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving a vehicle (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring for children (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IMPAIRMENTS

Please describe any impairments in the following categories related to the injury in question

Activity	Impairment	Response
Lifting	How much weight?	
Talking	Did the accident affect your speech?	
Hearing	Did the accident affect your hearing?	
Sitting	How long before shifting positions?	
Climbing	Difficulty with stairs?	
Balancing	Instability/use of cane?	
Stooping	Painful or difficult	
Driving	How long?	
Feeling	Numbness/tingling, or weakness?	
Reaching	Difficult reaching forward/overhead?	
Seeing	Double or blurred vision or blind spots?	
Standing	How long before taking a break?	
Walking	How long before taking a break?	
Bending	Painful or difficult	
Kneeling	Painful or difficult	

PAIN LEVELS



Body Part Area		
A	Headaches/Migraines (front)	Headaches/Migraines (back)
B	Neck (front)	Neck (back)
C	Shoulders (front)	Shoulders (back)
D	Biceps	Triceps
E1	Upper Torso (chest)	Upper Torso (back)
E2	Lower Torso (front)	Lower Torso (back)
F	Forearms (top)	Forearms (back)
G	Wrists (top)	Wrists (bottom)
H	Hands (top)	Hands (bottom)
I	Genitalia	Buttocks
J	Quadriceps (front)	Quadriceps (back)
K	Shins	Calves
L	Feet/Ankles (top)	Feet/Ankles (bottom)

Description	
1	1. The first row of the table is highlighted in light blue.
2	2. The second row of the table is highlighted in light blue.
3	3. The third row of the table is highlighted in light blue.
4	4. The fourth row of the table is highlighted in light blue.
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46	46. The forty-sixth row of the table is highlighted in light blue.
47	47. The forty-seventh row of the table is highlighted in light blue.
48	48. The forty-eighth row of the table is highlighted in light blue.
49	49. The forty-ninth row of the table is highlighted in light blue.
50	50. The fiftieth row of the table is highlighted in light blue.
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52	52. The fifty-second row of the table is highlighted in light blue.
53	53. The fifty-third row of the table is highlighted in light blue.
54	54. The fifty-fourth row of the table is highlighted in light blue.
55	55. The fifty-fifth row of the table is highlighted in light blue.
56	56. The fifty-sixth row of the table is highlighted in light blue.
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67	67. The sixty-seventh row of the table is highlighted in light blue.
68	68. The sixty-eighth row of the table is highlighted in light blue.
69	69. The sixty-ninth row of the table is highlighted in light blue.
70	70. The seventieth row of the table is highlighted in light blue.
71	71. The seventy-first row of the table is highlighted in light blue.
72	72. The seventy-second row of the table is highlighted in light blue.
73	73. The seventy-third row of the table is highlighted in light blue.
74	74. The seventy-fourth row of the table is highlighted in light blue.
75	75. The seventy-fifth row of the table is highlighted in light blue.
76	76. The seventy-sixth row of the table is highlighted in light blue.
77	77. The seventy-seventh row of the table is highlighted in light blue.
78	78. The seventy-eighth row of the table is highlighted in light blue.
79	79. The seventy-ninth row of the table is highlighted in light blue.
80	80. The eightieth row of the table is highlighted in light blue.
81	81. The eighty-first row of the table is highlighted in light blue.
82	82. The eighty-second row of the table is highlighted in light blue.
83	83. The eighty-third row of the table is highlighted in light blue.
84	84. The eighty-fourth row of the table is highlighted in light blue.
85	85. The eighty-fifth row of the table is highlighted in light blue.
86	86. The eighty-sixth row of the table is highlighted in light blue.
87	87. The eighty-seventh row of the table is highlighted in light blue.
88	88. The eighty-eighth row of the table is highlighted in light blue.
89	89. The eighty-ninth row of the table is highlighted in light blue.
90	90. The ninetieth row of the table is highlighted in light blue.
91	91. The ninety-first row of the table is highlighted in light blue.
92	92. The ninety-second row of the table is highlighted in light blue.
93	93. The ninety-third row of the table is highlighted in light blue.
94	94. The ninety-fourth row of the table is highlighted in light blue.
95	95. The ninety-fifth row of the table is highlighted in light blue.
96	96. The ninety-sixth row of the table is highlighted in light blue.
97	97. The ninety-seventh row of the table is highlighted in light blue.
98	98. The ninety-eighth row of the table is highlighted in light blue.
99	99. The ninety-ninth row of the table is highlighted in light blue.
100	100. The hundredth row of the table is highlighted in light blue.

0 - Pain free.

1 - **Mild.** Pain is very mild, barely noticeable. Most of the time you don't think about it.

2 - **Minor pain.** Annoying and may have occasional stronger twinges.

3 - **Uncomfortable.** Pain is noticeable and distracting, however, you can adjust to it.

4 - **Moderate.** If you are deeply involved in an activity, it can be ignored for some time, but it is still distracting.

5 - **Distracting.** Mid-ranged pain. It can't be ignored for more than a few minutes

6 - **Distressing.** Moderately strong pain that interferes with normal daily activities. Difficulty concentrating.

7 - **Severe.** Pain that dominates your senses and significantly limits your ability to perform daily activities.

8 - **Intensely Severe.** Severely limited physical activity. Conversing requires great effort.

9 - **Excruciating.** Unable to converse. Crying out and/or moaning uncontrollably.

10 - **Unspeakable.** Bedridden, possibly delirious. Very few people experience this pain.

[illegible]

COGNITIVE ISSUES/TRAUMATIC BRAIN INJURY/PSYCHOLOGICAL

Please use this area to list cognitive issues as related to your injuries and associated limitations.

Cognitive/Psychological Impairment	Severity		
	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>
Short-term memory	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>
Long-term memory	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>
Attention and concentration	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>
Word finding issues	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>
Expressing ideas or communicating	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>
Difficulty understanding verbal or written information	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>
Anxiety, depression, PTSD	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>
Other: Please list	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>

ADDITIONAL INFORMATION

Please use this area to note any information that did not fit in the form above, or additional information you feel is important for us to know as related to your injuries and associated limitations.

By typing or signing my name below, I affirm that all of the information provided on the previous pages of this document is true to the best of my knowledge.

If I am not the individual whose name and legal information is on this form, my name is _____.
My relationship to the individual is _____

And I affirm that all of the information provided throughout this document is true to the best of my knowledge.

Signature: _____

Date: _____