Patient Intake Information

All fields on this page are required.

Street Address: _____

City: _____

State: _____

ZIP Code: _____

Type of Report Requested: _____

- ☐ Vocational Evaluation
- ☐ Life Care Plan
- ☐ Forensic Economics
- ☐ Other / Not sure

If Other, please specify: _____

Kincaid Wolstein | VOCATIONAL & REHABILITATION SERVICES

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

Kincaid Wolstein Vocational and Rehabilitation Services
1 University Plaza, Suite 302, Hackensack, New Jersey 07601
www.KWVRS.com ■ Info@KWVRS.Com ■ Tel: (201) 343-0700

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

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List your current prescribed or over-the-counter medications **related to the** injury or condition in question			
Name	**Purpose**	**Frequency Taken**	**Strength**
Ex: Oxycodone	*Ex: Pain*	*2 tabs, 2x/Day*	*5-325mg*

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 of 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**
Ex: John Doe	*Neighbor/Friend/Home Attendant*	*30*

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			

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

HOUSEHOLD ACTIVITIES

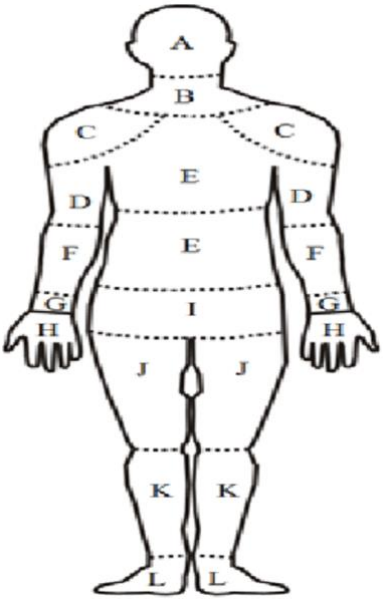
Before being injured, I did this independently				Now, I…		
	On Occasion	Frequently	Did not do this	Can still do this independently	Can do this in pain/less often	Need help/ Cannot Do
Rising from bed	☐	☐	☐	☐	☐	☐
Sitting/standing from toilet	☐	☐	☐	☐	☐	☐
Toilet hygiene (wiping)	☐	☐	☐	☐	☐	☐
Entering/exiting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

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			
A1	Headaches/Migraines (front)	A2	Headaches/Migraines (back)
B1	Neck (front)	B2	Neck (back)
C1	Shoulders (front)	C2	Shoulders (back)
D1	Biceps	D2	Triceps
E1	Upper Torso (chest)	E3	Upper Torso (back)
E2	Lower Torso (front)	E4	Lower Torso (back)
F1	Forearms (top)	F2	Forearms (back)
G1	Wrists (top)	G2	Wrists (bottom)
H1	Hands (top)	H2	Hands (bottom)
I1	Genitalia	I2	Buttocks
J1	Quadriceps (front)	J2	Quadriceps (back)
K1	Shins	K2	Calves
L1	Feet/Ankles (top)	L2	Feet/Ankles (bottom)

Description
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**. The pain can be ignored for some time during activities.
5-**Distracting**. Mid-ranged pain. It can't be ignored for more than a few minutes.
6-**Distressing**. Moderately strong, interferes in daily activities. Difficulty concentrating.
7-**Severe**. Pain that dominates your senses and limits your ability to perform 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.

Body Part	Constant/ Occasional	Lowest # in Past 30 Days	Highest # in Past 30 Days	Any Numbness, Tingling, Burning?

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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		
Short-term memory	Mild ☐	Moderate ☐	Severe ☐
Long-term memory	Mild ☐	Moderate ☐	Severe ☐
Attention and concentration	Mild ☐	Moderate ☐	Severe ☐
Word finding issues	Mild ☐	Moderate ☐	Severe ☐
Expressing ideas or communicating	Mild ☐	Moderate ☐	Severe ☐
Difficulty understanding verbal or written information	Mild ☐	Moderate ☐	Severe ☐
Anxiety, depression, PTSD	Mild ☐	Moderate ☐	Severe ☐
Other: Please list	Mild ☐	Moderate ☐	Severe ☐

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:_____