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CALIFORNIA STATE QUALIFIED MEDICAL EXAMINER  
SF, Richmond, Petaluma, Sacramento and Arcata, California

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### **New Patient Information Sheet**

Please confirm your appointment with our administrative office at the above mentioned telephone number and arrive 15 minutes prior to your appointment to complete any necessary paperwork.

1. We estimate the office visit will take between 1 to 3 hours depending on whether testing is indicated. Please, DO not bring children.
2. Dr. Rutchik, may request nerve and muscle testing. The EMG or electromyography is a nerve and muscle test that is in two parts; soft electrical shocks and a thin small needle. The testing may cause some mild discomfort, but has no lasting effects. You may return to your regular daily activities. This test takes approximately 30 to 60 minutes depending on complexity.
3. During the examination, you may be required to disrobe and wear a medical gown, which will be provided.
4. Also, please do not use any lotion products the day of the examination. Please remove all jewelry before the examination.
5. Bring all medication bottles and list them on the questionnaire.
6. Notify the doctor if you have a pacemaker or have a blood clotting disease.
7. **Please fill out the enclosed questionnaires and mail them back with our self-addressed and stamped envelope that was enclosed in your packet. This will help to provide Dr. Rutchik with your information to review before you visit, so he can have a more thorough evaluation with you. This will allow him to ask you important questions and compare it to your medical records.**

Call our administrative office if you have any questions.

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**CALIFORNIA STATE QUALIFIED MEDICAL EXAMINER**

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Medical Questionnaire

1-8

Date of Examination	Location of Examination
Name	Social Security Number
Address	Age Height and Weight
Telephone	Date of Birth
Employer <b>ON Date of Injury</b>	Which hand do you use to write with?
Injured Body Part:	<u>Date of Injury:</u>

**History of Present Illness**

9. Describe the event(s) that took place that caused this injury?  
(Use the back of this sheet for more room.)

10. What was the address, place and name of the business where this event occurred? **Please list the date of hire. Do you still work for this company? New Employer? What days do you work and *what are you hours?* (For present and past jobs).**

11. What was your job title and job description when this injury occurred?

12. What were the routine tasks of the job? **If not the same, what are the routine tasks of your job now?**

13. <u>How many pounds lifting and how often?</u> Did you do bending, climbing, reaching?	
14. Were you engaged in the routine tasks of your job when this injury took place?	
15. Describe when and what kind of treatment that you received immediately after the accident? Give dates and practitioner's name. <u>Please include any tests and results.</u> MRIs? EMGs? Epidural injections, etc? (Please use other side if necessary)	
<b>Past Medical History</b>	
16. Have you had prior injuries to this body part <i>or area of your body</i> ? Please describe. <u>Include prior surgeries &amp; dates &amp; treatment.</u> <b>List all other Medical Conditions. Family history?</b>	
17. If you answered "yes" to the above question, had your problem resolved completely before the injury in question occurred? If not, describe your condition prior to the injury.	
18. Describe your prior <b>THREE</b> jobs.	
19. Did you have worker injury claims at these jobs?	
20. Current Medications (For ALL Conditions)	
21. Allergies to medications?	22. Do you use alcohol, smoke, or recreational drugs?

<b>Current Complaints/Status</b>	
24. What are your current complaints? Do you have pain? If yes, describe what it feels like and where exactly it is. What number 0-10 best describes your pain? How frequent is your pain?	25. Do you have pain at rest? Is there pain in a seated position, standing position or while walking?
26. What activities make the pain worse?	27. What makes the pain better?
<b>Current Activities</b>	
28. What is the heaviest thing you lifted last week?	29. Do you drive? Did you drive today?
30. Do you have children at home? What ages? Marriage status?	31. Do you receive disability compensation?
32. List hobbies & daily activities?	
33. List your present treatment program? Include name/type of practitioners, how often per month? Physical therapy? Acupuncture? Chiropractor?	
34. What is your current job status? Please circle correct answer. a. Working normal duty b. Modified duty c. Out of work because no modified duty exists d. Totally disabled  Please list dates that you were not working up until the present.	
35. Are you receiving vocational rehabilitation? Please describe.	

Js Rutchik, MD, MPH Questionnaire  
 Pages 4 and 5, from AMA Guidelines, 5<sup>th</sup> edition

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**I. Pain (Self-report of Severity)**

A. Rate how severe your pain is right now, at this moment (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 No pain Most severe pain can imagine

B. Rate how severe your pain is at its worst (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 None Excruciating

C. Rate how severe your pain is on the average (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 None Excruciating

D. Rate how much your pain is aggravated by activity (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Activity does not aggravate pain Excruciating following any activity

Sum score of Section I: A-D = Total pain severity/4 = \_\_\_\_\_

E. Rate how frequently you experience pain (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Rarely All of the time

Add total pain severity score (Items A-D/4) to score for item E = \_\_\_\_\_

Total pain severity score (range from 0 to 20) = \_\_\_\_\_

**II. Activity Limitation or Interference**

A. How much does your pain interfere with your ability to walk 1 block? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not restrict ability to walk Pain makes it impossible for me to walk

B. How much does your pain prevent you from lifting 10 pounds (a bag of groceries)? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not prevent from lifting 10 pounds Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to sit for 1/2 hour? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not restrict ability to sit for 1/2 hour Impossible to sit for 1/2 hour

D. How much does your pain interfere with your ability to stand for 1/2 hour? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Pain does not interfere with ability to stand at all Unable to stand at all

E. How much does your pain interfere with your ability to get enough sleep? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not prevent me from sleeping Impossible to sleep

F. How much does your pain interfere with your ability to participate in social activities? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere with social activities Completely interferes with social activities

G. How much does your pain interfere with your ability to travel up to 1 hour by car? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere with ability to travel 1 hour by car Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your daily activities? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere with my daily activities Completely interferes with my daily activities

I. How much do you limit your activities to prevent your pain from getting worse? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not limit activities Completely limits activities

J. How much does your pain interfere with your relationship with your family/partner/significant others? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere with relationships Completely interferes with relationships

K. How much does your pain interfere with your ability to do jobs around your home? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere Completely unable to do any job around home

L. How much does your pain interfere with your ability to shower or bathe without help from someone else? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere at all My pain makes it impossible to shower or bathe without help

