# SELF - REPORT OF INDEPENDENT CHIROPRACTIC / MEDICAL EXAMINATION

Patient's name: _____ Date of Examination: _____

Examining doctor: _____ Address _____

What time did you arrive at the office? _____ AM PM

How long did you wait to see the doctor? _____

How long were you actually with the doctor? _____

How much time was spent: answering questions? _____, for the actual examination? _____

What time did you leave the doctor's office? _____AM PM.

Were you questioned by a nurse/staff member before seeing the doctor? YES NO

If yes, for how long? _____

Were any x-rays taken? YES NO If yes, of what part of the body? _____

Please list any questions you remember the doctor asking you and your response to the question:

_____

_____

_____

Please list any comments the doctor made to you about your case, your injuries or his (the doctor's) opinions:

_____

_____

_____

Other comments or information: _____

**The Examination:**

Please note if the insurance company's doctor did any of the following orthopedic, neurological or chiropractic tests on you:

Did the doctor tap your reflexes

1. At your forearm? ❑Yes ❑No
2. At the inside of your elbow? ❑Yes ❑No
3. At the back of your elbow? ❑Yes ❑No
4. At your knees? ❑Yes ❑No
5. At your Achilles' tendons (back of your foot/heel) ❑Yes ❑No

Did the doctor roll a mini-pinwheel on your **arms**? ❑Yes ❑No and/ or on your **legs**? ❑Yes ❑No

Did the doctor check the strength of the muscles in your shoulders, arms and forearms? ❑Yes ❑No

Did the doctor check the strength of the muscles in your legs? ❑Yes ❑No

Did the doctor have your bend your neck forward and backward? ❑Yes ❑No
Did the doctor have you bend your head/neck from side to side? ❑Yes ❑No
Did the doctor have you turn your neck from side to side? ❑Yes ❑No
Did the doctor use a device to check your range of motion? ❑Yes ❑No **-or-**
Did the doctor watch you as you bent through the various motions? ❑Yes ❑No

Did any of these tests cause you any pain? If yes, which one? _____

Did the doctor place his hands on your head and apply downward pressure into your neck? ❑Yes ❑No
- How did this make you feel? _____

Did the doctor do this again while your head was bent to the right? ❑Yes ❑No or left? ❑Yes ❑No
- How did this make you feel? _____

Did the doctor put his hands under the back of your head and gently traction or lift your head up ❑Yes ❑No
- How did this make you feel? _____

Did the doctor have you bend over to try and touch your toes? ❑Yes ❑No
Did the doctor have you bend your torso(low back) backwards? ❑Yes ❑No
Did the doctor have you bend your waist to the right? ❑Yes ❑No and/or to the left? ❑Yes ❑No
Did the doctor use a device to check your range of motion? ❑Yes ❑No -or-
Did the doctor watch you bend through the various motions? ❑Yes ❑No

Did any of these tests cause you any pain? If yes, which one? _____

Did the doctor have you bend backward while turning to the right? ❑Yes ❑No And/or to the left? ❑Yes ❑No

Did the doctor have you lay down on your back and hold both of your legs in the air at the same time? ❑Yes ❑No
- How did this make you feel? _____

While lying on your back, did the doctor stretch your left leg up? ❑Yes ❑No
- How did this make you feel? _____

While lying on your back, did the doctor stretch your right leg up? ❑Yes ❑No
- How did this make you feel? _____

While lying on your back, did the doctor bend your left or right leg in a figure 4? ❑Yes ❑No
- How did this make you feel? _____

Did the doctor have you lay down on your stomach and lift your right leg backward? ❑Yes ❑No
Did the doctor have you lay down on your stomach and lift your left leg backward? ❑Yes ❑No
- How did this make you feel? _____

Did the doctor have you lay down on your stomach and touch your right heel to your right buttock? ❑Yes ❑No
Did the doctor have you lay down on your stomach and touch your left heel to your left buttock? ❑Yes ❑No
Did the doctor have you lay down on your stomach and touch your right heel to your left buttock? ❑Yes ❑No
Did the doctor have you lay down on your stomach and touch your left heel to your right buttock? ❑Yes ❑No

- How did this make you feel? _____

Did the doctor feel the muscles of your spine, back and neck? ❑Yes ❑No
Where there any tender areas when he felt your back and neck muscles? ❑Yes ❑No

Please use the reverse side of this paper for any other comments you have about the IME doctors exam or your experience at the IME doctor's office.

Signed: _____ Date: _____