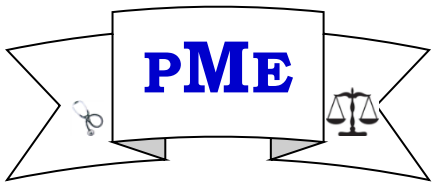



*Board Certified Orthopedic Surgeons*

# PROFESSIONAL MEDICAL EVALUATIONS, P.A.

## STANDARD I.M.E. FORM

You have presented for a third-party evaluation. In order to assess your injury, please fill out this form completely.

Name_____Date_____

Address_____City_____State____Zip_____

Date of Birth_____ Age_____ Social Security # __xxx-xx-_____

Home Phone No. (_____)_____ Work Phone No. (_____)_____

Emergency Contact Name/Phone _____

Height _____ Hair Color _____

Weight _____ Eye Color _____

Distinguishing Marks, if any_____

Date of Accident_____ What did you hurt and how? _____

_____

| | | |
|---|---|---|
| Did you go to the hospital after the injury? | ____Yes | ____No If yes, when?_____ |
| If yes, were you admitted? | ____Yes | ____No |
| Were you taken by ambulance? | ____Yes | ____No |
| Are you currently undergoing treatment? | ____Yes | ____No If yes, how often?_____ |
| Were x-rays taken? | ____Yes | ____No |
| If Yes, Did you bring them with you? | ____Yes | ____No |
| Were MRI's performed? | ____Yes | ____No |
| If Yes, Did you bring them with you? | ____Yes | ____No |
| Have you had any previous accidents? | ____Yes | ____No If yes, when?_____ |
| Have you had any previous injuries? | ____Yes | ____No If yes, when?_____ |
| Have you had any subsequent accidents? | ____Yes | ____No If yes, when?_____ |

**Under these circumstances, the physician will evaluate your history and present condition. As such, there is no representation of a physician/patient relationship. This means that there will be no discussion regarding diagnosis, nor recommendations for treatment. There is no patient confidentiality in a third-party evaluation. The sole purpose of this examination is for the use of the party ordering the examination.**

I understand and consent:_____ Date:_____

Witness _____

Signature

# PROFESSIONAL MEDICAL EVALUATIONS, P.A.

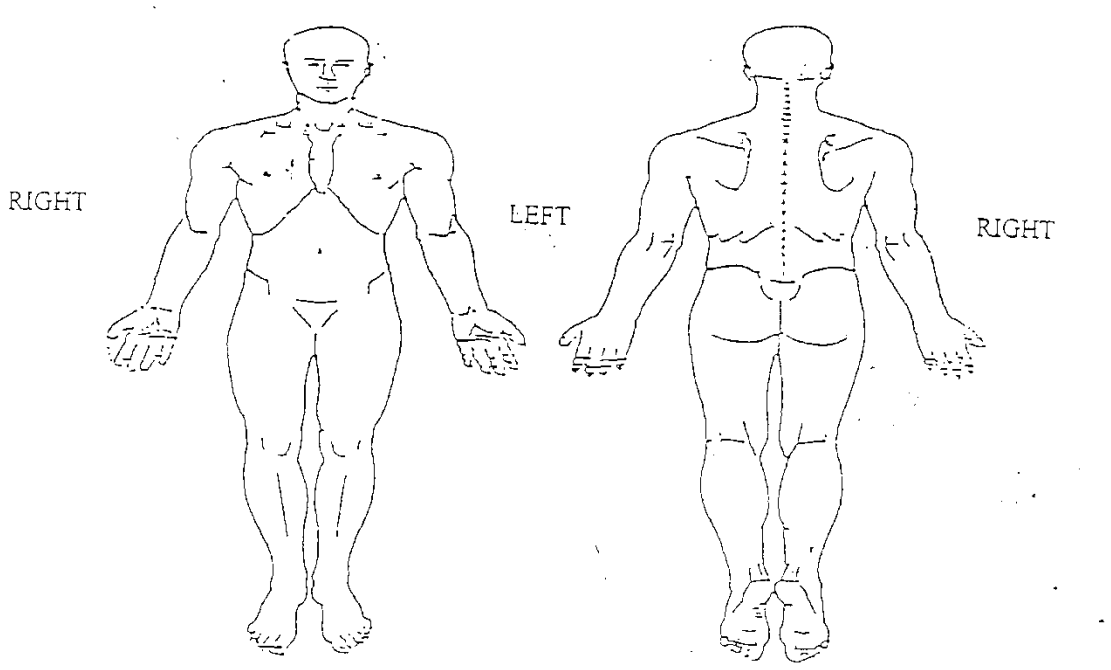
## PAIN DRAWING

Your Name _____

Date _____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

| Aching | Numbness | Pins & Needles | Burning | Stabbing | Other |
|---|---|---|---|---|---|
| ◊ ◊ ◊ | = = = | O O O | X X X | / / / | • • • |




Please grade the severity of your pain by circling the number on the scale below

(Mild) 1 2 3 4 5 (Severe)

Signature of Patient_____

# PHOTOGRAPH AUTHORIZATION

I, _____, authorized the staff of Professional Medication Evaluations, P.A. to take a facial photograph for the purpose of proper identification in regards to the Independent Medical Evaluation for which I was sent and for my medical record.

In addition, and if necessary, I authorize the staff of Professional Medical Evaluations, P.A. to photograph the areas of injury that were sustained in my accident.

_____
Signature of Patient

_____
Date of Examination

_____
Signature of Witness