MEDICAL CARE QUESTIONNAIRE
TO BE COMPLETED BY CLIENT
AFTER *EVERY* VISIT TO PHYSICIAN, OR HEALTH, VOCATIONAL OR MEDICAL FACILITY
(RETURN TO YOUR ATTORNEY)

NAME OF CLIENT: SOCIAL SECURITY NO:

1. ☐ SOCIAL SECURITY CASE	☐ WORKERS COMPENSATION CASE	☐ VETERANS CASE

DATE(S) OF MEDICAL TREATMENT:
NAME OF PHYSICIAN SEEN (OR OTHER HEALTH PROFESSIONAL):
PHYSICIAN SPECIALITY:
NAME OF MEDICAL FACILITY:
ADDRESS:
WHO REFERRED YOU TO THIS MEDICAL CARE?:
HOW LONG DID YOU SEE THE PHYSICIAN OR OTHER PRIVIDER (DO NOT COUNT WAITING TIME)?: HOURS: MINUTES:
WHAT DID YOU TELL THE PHYSICIAN OR HEALTH CARE PROVIDER ABOUT YOUR HEALTH?:
WHAT DID THE PHYSICIAN OR HEALTH CARE PROVIDER TELL YOU ABOUT YOUR HEALTH?:
WHAT TREATMENT OR TESTING WAS PROVIDED?
WHAT MEDICATIONS WERE PRESCRIBED OR RENEWED?: WERE YOUR MEDICATIONS CHANGED OR INCREASED? ☐YES ☐NO
WHAT PHYSICAL OR OTHER RESTRICTIONS OF YOUR ACTIVITIES WERE RECOMMENDED?:
ARE YOU SCHEDULED TO RETURN FOR ADDITIONAL CARE OR FOLLOWUP?: ☐YES ☐NO IF "YES", WHEN?: WHY?:
WERE YOU RATED? ☐YES ☐NO IF "YES", WHAT PART OF BODY WAS RATED?: RATING GIVEN:
PLEASE GIVE ANY OTHER INFORMATION YOU CONSIDER IMPORTANT ABOUT YOUR VISIT: