Standard Insurance Company

CTA Benefits
PO Box 2773 Portland OR 97208
Tel 800.522.0406 Fax 888.414.0390

Medical Questionnaire

Name:	Claim Number:	Date:
Date of Birth:	Employer:	

Return to:

Name:	Phone No.:	Fax No.:
	( )	( )

DEAR PROVIDER:

The purpose of this form is to help us determine whether the clinical condition of this claimant is causing functional impairment. Please complete the following report as completely as possible and provide copies of all objective data.

1. **Primary Diagnosis:** _____
   Major source of impairment

   Secondary Diagnosis: _____
   Other diagnoses that might contribute to impairment

2. Describe the symptoms and clinical findings, and how any diagnoses affect the claimant's functional abilities.

   _____

   _____

3. *Based upon objective findings, please indicate the amount of activity this claimant can perform in an 8-hour work day, for any employer. Indicate the functional capacities of this claimant given two breaks, positional changes, and meal break(s).*

	1 Hr.	2 Hrs.	3 Hrs.	4 Hrs.	5 Hrs.	6 Hrs.	7 Hrs.	8 Hrs.	NOT AT ALL
a. Sitting	☐	☐	☐	☐	☐	☐	☐	☐	☐
b. Standing	☐	☐	☐	☐	☐	☐	☐	☐	☐
c. Walking	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Occasional	Frequent	Constant
d. Reaching	☐	☐	☐
e. Handling	☐	☐	☐
f. Fingering	☐	☐	☐

What assistive devices might improve this claimant's ability to perform work activities? _____

_____

_____

4. Activities claimant can perform in an 8-hour work day:

		OCCASIONALLY 1% TO 33%	FREQUENTLY 34% TO 66%	CONTINUOUSLY 67% TO 100%
Lift	1-10 lbs.			
	11-20 lbs.			
	21-50 lbs.			
	51-75 lbs.			
	76-100 lbs.			
Carry	1-10 lbs.			
	11-20 lbs.			
	21-50 lbs.			
	51-75 lbs.			
	76-100 lbs.			
Push/Pull	1-10 lbs.			
	11-20 lbs.			
	21-50 lbs.			
	51-75 lbs.			
	76-100 lbs.			

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Name:

5. Current medication(s): (Include dosage and frequency)
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
6. Current treatment and/or therapy: _____
   _____
   _____
7. Referrals to other providers:
   Name: _____ Specialty: _____
   Phone: _____ Date: _____
   Name: _____ Specialty: _____
   Phone: _____ Date: _____
8. Hospitalizations within the past 12 months:
   Admit Date: _____ Discharge Date: _____ Reason: _____
   Admit Date: _____ Discharge Date: _____ Reason: _____
9. Surgery: ☐ Anticipated (Date and Procedure): _____
   ☐ Previous surgery(ies) within the past 12 months: _____
   _____
10. Date first seen for this condition: _____ /_____ /_____ (month / day / year) Date last seen: _____ /_____ /_____ (month / day / year) Date of next visit: _____ /_____ /_____ (month / day / year)
11. Assessment and treatment are complicated by:
    ☐ Contributing factors such as depression, anxiety, etc.
    ☐ Exaggeration, inconsistent findings or subjective complaints out of proportion to objective findings
    ☐ Malingering
    ☐ Dependence on drugs/medication/alcohol. Specify: _____
    ☐ Other (please describe): _____
12. Do you expect the individual's condition to: ☐ Improve ☐ Remain the same ☐ Regress
13. Anticipated return to work date: _____ /_____ /_____ (month / day / year)
14. Comments: _____
    _____
    _____
    _____

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false, or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Physician's Signature:		Date:		
Physician's Name: *(Please print.)*		Specialty:		
Address:		City:	State:	Zip:
Taxpayer ID #:	Phone No.: ( )	Fax No.: ( )		