

**Symptom & Impairment Questionnaire | [Client Name] | DOB: [mm/dd/yyyy]**

*Please note that the value of your assessment depends on the degree to which it is supported by objective findings, your observations of your patient, and your patient's reported symptoms.*

1. Please provide dates of treatment: First: \_\_\_\_\_ Last: \_\_\_\_\_
  
2. Is symptom tracking via self-report a clinically valid method for documenting the frequency and severity of your patient's symptoms and resulting functional limitations? \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**
  
3. Have you reviewed the attached Symptom Diary Summary Report for the time period from [mm/dd/yyyy] to [mm/dd/yyyy]? \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**
  
4. Do you believe your patient is a malingerer? \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**  
*If you mark "Yes," please briefly explain your response.*
  
  
  
  
  
  
  
  
  
  
5. Are your patient's reported symptoms recorded in the attached Symptom Diary Summary Report consistent with the medical evidence of illness or injury?  
*Please be sure to briefly explain your response with reference to the medical records and/or literature.* \_\_\_\_\_ **Yes** \_\_\_\_\_ **No** \_\_\_\_\_ **Partially**

*For the next question, please assume continuous, full-time work (40 hours per week) in a competitive (non-sheltered) work environment.*

6. Assuming your patient tried to work:
  - a. Is it likely they would be absent, arrive late, or leave early *two days per month or more*? \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**
  
  - b. Is it likely they would be off-task *on average more than 15%* of the time when they should be working? \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**
  
  - c. Is it likely working would exacerbate their condition? \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date