§194 Form: Claimant's Consultative Examination Questionnaire

To: ***Client's Name***

CONSULTATIVE EXAMINATION QUESTIONNAIRE

Appointment scheduled with __Doctor__, on __Date__, at _Time_ .

1) Did you actually see the doctor named above? __ Yes or __ No
If no, please state the name of the doctor you saw: _____

2) What is the doctor's specialty? (Orthopedic, cardiac, etc.)_____

3) Was this the first time you have ever seen this doctor? __ Yes or __ No

4) Did the doctor examine you in an office or in an examining room? _____

5) Was anyone else present during the exam? (Nurse or assistant) _____

6) What did the doctor do? _____

7) Did the doctor draw blood or take x-rays? If x-rays, what part of the body? _____

8) Did the doctor have you do any test with a machine? __ Yes or __ No
Explain: _____

9) Were you asked to fill out any forms or questionnaires related to your disability?
__ Yes or __ No
Explain:_____
_

10) Did you feel the doctor gave you a thorough exam? __ Yes or __ No
Explain:_____
_

11) How much time did the doctor spend with you? _____

12) Did the doctor have any of your medical records from your treating physicians?
__ Yes or __ No
Explain:_____
_

13) Was the doctor __ rude or __ nice?
Explain:_____
_

14) Did you ask Social Security to send a copy of the exam to your doctor?
__ Yes or __ No
Which doctor? _____

15) Are there any comments that you would like to make about this exam?

__ Yes or __ No

Explain:_____

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Please complete this form after your exam and return it to us as soon as possible.
A self-addressed stamped envelope is enclosed for your use.