# Instructions for Attorneys on completing the Patient Questionnaire

(please **remove** **this cover page** before providing to the questionnaire to the patient)

In order to minimize the amount of time that is spent examining the patient and allow the doctor to a complete a holistic evaluation of the patient, the following pages must be completed and provided to the doctor within two weeks after receiving confirmation of the scheduled appointment.

The optimum method is to sit down with the patient and help them complete the form while they are in the Attorney’s office.

If possible, this form should be completed on a computer using MS Word 2007 or 2010. When completed with a computer it is not critical that the page breaks and page count remain the same.

If there is insufficient space to completely answer a question, use the continuation sheet (Part 4) at the end of the questionnaire and add “See Part 4” to indicate the continuation.

Part 1C asks for the patient’s work history since age 18. This information can be obtained at the local Social Security Office if necessary.

Please provide the best answer possible, however, the doctor will cover the entire form with the patient and address any items that need clarification or need to be added.

Please advise the patient that if they have any questions following the examination, they should contact their attorney.

Attorneys should fax the completed form to 913-894-4055 or email it to [office@koprivicamd.com](mailto:office@koprivicamd.com).

# Instructions for Patients on completing the Patient Questionnaire

In order to minimize the amount of time that is spent examining the patient and allow the doctor to a complete a holistic evaluation of the patient, the following pages should be completed and provided to the doctor within two weeks after receiving confirmation of the scheduled appointment.

Patients will require a **minimum of two (2) hours** to meet with the doctor. This **may extend to five (5) hours** depending on the extent of the injuries, interview and measurements that must be completed.

If there is insufficient space to completely answer a question, use the continuation sheet (Part 4) at the end of the questionnaire and add “See Part 4” to indicate the continuation.

Part 1C asks for the patient’s work history since age 18. This information can be obtained at the local Social Security Office if necessary.

Please provide the best answer possible, however, the doctor will cover the entire form with the patient and address any items that need clarification or need to be added.

Instructions on how to get to the doctor’s office are at the web site: [www.koprivicamd.com](http://www.koprivicamd.com).

If a patient has any questions following the examination, they should contact their attorney.

The attorneys should send the completed form to the doctor.

Appointment Date:

# Part 1. Patient Information

A. GENERAL

|  |  |  |
| --- | --- | --- |
| 1) Name (First – Middle Initial – Last)  2) Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3) Age \_\_\_\_\_\_\_\_\_\_  4) SSN: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ | | |
| 5) Address (Street, City, State Zip) | | |
| 6) Phone Numbers a) Home | c) Cell | |
| b) Work | d) Fax | |
| 7) Email | | |
| 8) Current employer a) Company Name | | b) Phone |
| c) Address (Street, City, State Zip) | | |

B. EDUCATION AND SPECIAL TRAINING

|  |  |
| --- | --- |
| 1) Highest grade completed | 2) High School Graduation Year |
| 3) Trade Schools or Vocational Training or Apprenticeships and Year completed | |
| 4) Certifications and Year completed | |
| 5) College degrees and Year awarded | |

C. EMPLOYMENT HISTORY (start at age 18)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  | If Injury on Job: | |
| Employer  From-To  (Month/Year) | Type of work | Reason for leaving | Injury on job? (Yes or No) | Settlement given ?  (Yes or No) | Percent Disability awarded |
|  |  |  |  |  |  |
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Continued in Part 4? YES NO (circle one)

D. MILITARY SERVICE (circle one) YES NO (if YES, complete the following)

|  |  |  |
| --- | --- | --- |
| 1) Date entered Service | 2) Date left Service | 3) Branch of Service |
| 4) Military Job(s) | | |

E. PERSONAL HISTORY

1) Marital Status (begin at age 18)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| From (Month/Year) | To (Month/Year) | Status (check one) | | Children |
|  |  | 🞏 Single  🞏 Co-habitate  🞏 Married | 🞏 Divorced  🞏 Widowed |  |
|  |  | 🞏 Single  🞏 Co-habitate  🞏 Married | 🞏 Divorced  🞏 Widowed |  |
|  |  | 🞏 Single  🞏 Co-habitate  🞏 Married | 🞏 Divorced  🞏 Widowed |  |
|  |  | 🞏 Single  🞏 Co-habitate  🞏 Married | 🞏 Divorced  🞏 Widowed |  |
|  |  | 🞏 Single  🞏 Co-habitate  🞏 Married | 🞏 Divorced  🞏 Widowed |  |
|  |  | Total Children | |  |

2) Hobbies

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Hobby | From  (Year) | To  (Year) | Pre-injury  (Check if YES) | Post-injury  (Check if YES) |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |

3) Personal considerations

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Condition | YES | NO | Amount | Attempts to | |
|  |  |  |  | Quit | Rehab |
| Smoke |  |  |  |  |  |
| Alcohol use |  |  |  |  |  |
| Illicit drugs |  |  |  |  |  |

F. MEDICAL HISTORY

1) What is your

|  |  |  |  |
| --- | --- | --- | --- |
| a) Height | b) Weight | c) Usual Blood Pressure | d) Usual Pulse |

2) Medications

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | From  (Month/Year) | To  (Month/Year) | Pre-injury  (Check if YES) | Post-injury  (Check if YES) |
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3) Allergies

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Allergy | From  (Year) | To  (Year) | Pre-injury  (check if YES) | Post-injury  (check if YES) |
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4) Immediate Relatives (Father, Mother, Brothers, Sisters)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Relationship | Living  (Check if YES) | Age at Death | Year of Death | Cause of Death |
| Father |  |  |  |  |
| Mother |  |  |  |  |
|  |  |  |  |  |
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5) Family Medical History (Check if YES)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Condition | Father | Mother | Grandparent | Children |
| Diabetes |  |  |  |  |
| Easy Bleeding |  |  |  |  |
| Obesity |  |  |  |  |
| Allergy |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| Jaundice |  |  |  |  |
| Gout |  |  |  |  |
| High Blood Fats |  |  |  |  |
| Stroke |  |  |  |  |
| Alcoholism |  |  |  |  |
| Asthma |  |  |  |  |
| Heart Trouble |  |  |  |  |
| Tuberculosis |  |  |  |  |
| Cancer |  |  |  |  |
| Psychiatric Illness |  |  |  |  |
| Hearing Aids |  |  |  |  |
| Back surgery |  |  |  |  |
| Other |  |  |  |  |
|  |  |  |  |  |
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6) Patient Medical History Y=YES N=NO NS=NOT SURE

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Condition | Y | N | NS | Condition | Y | N | NS | Condition | Y | N | NS |
| Scarlet fever |  |  |  | Emphysema |  |  |  | “Trick” or locked knee |  |  |  |
| Rheumatic fever |  |  |  | Limit of joint motion |  |  |  | Foot trouble |  |  |  |
| Swollen or painful joints |  |  |  | Cramps in your legs |  |  |  | Neuritis |  |  |  |
| Frequent or severe headache |  |  |  | Gall bladder trouble (gallstones) |  |  |  | Paralysis (include infantile) |  |  |  |
| Dizziness/fainting spells |  |  |  | Jaundice or Hepatitis |  |  |  | Epilepsy or fits |  |  |  |
| Eye trouble |  |  |  | Tuberculosis |  |  |  | Car, train, sea or air sickness |  |  |  |
| Ear, nose or throat trouble |  |  |  | Broken bones |  |  |  | Frequent trouble sleeping |  |  |  |
| Hearing loss |  |  |  | Tumor, growth, cyst, cancer |  |  |  | Depression or excessive worry |  |  |  |
| Chronic or frequent colds |  |  |  | Rupture/hernia |  |  |  | Loss of memory or amnesia |  |  |  |
| Severe tooth/gum trouble |  |  |  | Piles or rectal disease |  |  |  | Nervous trouble of any sort |  |  |  |
| Sinusitis |  |  |  | Frequent/painful urination |  |  |  | Periods of unconsciousness |  |  |  |
| Hay fever |  |  |  | Bed wetting since age 12 |  |  |  | Gout |  |  |  |
| Head injury |  |  |  | Kidney stones or blood in urine |  |  |  | Hardening of arteries |  |  |  |
| Skin diseases |  |  |  | Sugar or albumin in urine |  |  |  | Anemia/blood disorder |  |  |  |
| Thyroid trouble |  |  |  | STD – syphilis, gonorrhea |  |  |  | Glaucoma |  |  |  |
| Adverse reaction to serum, drug, medicine or foods |  |  |  | Frequent indigestion, stomach  ulcer |  |  |  | Stomach, liver or intestinal trouble |  |  |  |
| Asthma |  |  |  | Recent weight gain or loss |  |  |  | Abnormal chest X-ray |  |  |  |
| Shortness of breath |  |  |  | Arthritis, rheumatism, or bursitis |  |  |  | Abnormal G.I. X-ray |  |  |  |
| Pain or pressure in chest |  |  |  | Bone, joint or other deformity |  |  |  | Abnormal EKG |  |  |  |
| Chronic cough |  |  |  | Lameness |  |  |  | Use tobacco |  |  |  |
| Palpitation/pounding heart |  |  |  | Loss of finger or toe |  |  |  | Use alcohol |  |  |  |
| Heart Trouble |  |  |  | Kidney/bladder trouble |  |  |  | Recurrent back pain |  |  |  |
| High or low blood pressure |  |  |  | Herpes |  |  |  | Painful or “trick” shoulder or Elbow |  |  |  |
| Bronchitis |  |  |  |  |  |  |  |  |  |  |  |
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| FEMALES ONLY |  |  |  | Been treated for a female disorder |  |  |  | Had a change in menstrual Pattern? |  |  |  |

# Part 2. Injury Information

A. DESCRIBE THE INJURY

|  |  |  |
| --- | --- | --- |
| 1) Date of injury | 2) Employers name at time of injury | |
| 3) What parts of the body were injured? | | |
| 4) How did the injury occur? | | |
| 5) When did you stop work? | 6) What date were you released to return to work (RTW)? | 7) What doctor signed your RTW release? |
| 8) What restrictions (if any) were given by the above doctor when you returned to work? | | |
| 9) What date were the restrictions removed? | | |

B. PREVIOUS INJURIES

List previous injuries to the same body parts

|  |  |  |  |
| --- | --- | --- | --- |
| Body Part | Date of Previous Injury  (Month/Year) | Corrective actions or surgeries | Names of attending Physicians |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

C. POST INJURY ACTIONS

1) Describe all symptoms, when they started, how (if) they are changing, location, frequency of occurrence, duration, intensity/quality with particular attention to time and circumstances of onset, course of condition, note presence of pain, numbness, weakness, stiffness, etc.

Continued in Part 4? YES NO (circle one)

2) Corrective actions or surgeries

|  |  |  |
| --- | --- | --- |
| Body Part | Corrective actions or surgeries | Names of attending Physicians |
|  |  |  |
|  |  |  |
|  |  |  |

3) Describe how you have responded to treatment

4) Describe how the condition limits or interferes with which daily activities

|  |  |  |
| --- | --- | --- |
| Activity | Limited (Yes or No) | Describe limitations or reduction in activity or if activity has been given up |
|  |  |  |
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5) Patient’s perceptions

a) How long at one time and over an eight-hour period can the you do the following without serious discomfort? (Expressed in terms of hours and half hours, i.e. 0.5, 1.0. 1.5, 2.0, 2.5, etc.)

|  |  |  |  |
| --- | --- | --- | --- |
|  | At one time | Over an 8 hour period | Remarks |
| Sit |  |  |  |
| Stand |  |  |  |
| Walk |  |  |  |

b) How many pounds can you lift:

|  |  |
| --- | --- |
| 1) at frequent intervals? | 2) occasionally? |

D. Special tests or procedures (MRI, Cat Scan, etc)

|  |  |  |  |
| --- | --- | --- | --- |
| TYPE | DATE | RESULTS | ORDERING PHYSICIAN |
|  |  |  |  |
|  |  |  |  |
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E. What exercises do you usually do to stay physically fit?

|  |  |  |  |
| --- | --- | --- | --- |
| ACTIVITY | DURATION (minutes) | TO MINIUMUM HEART RATE | TIMES PER WEEK |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

# Part 3. Status of Disability Claim

|  |  |
| --- | --- |
| A. Currently on disability? | B. Expect to file future claims? |
| C. Future Restrictions? | |

# Part 4. Continued information

If any answers need additional information, please note the question number (1A2a, 3B5b, 4D8, etc.) and provide the necessary information. Use additional pages as necessary. Place the patient’s last name and date at the top of each page and number the pages, beginning with 11.

# Authorization to Release Information

I hereby authorize P. Brent Koprivica, MD, & Associates, PA, to release all or any portion of my records, including x-rays or lab results, and to permit any doctors or other employees to be interviewed regarding my diagnosis, care and treatment rendered by P. Brent Koprivica, MD, & Associates, PA.

This authorization includes, but is not limited to, my employer, insurance companies, unemployment and workers compensation carriers.

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

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Authorization to Discuss Information with Family Members

I hereby authorize P. Brent Koprivica, MD, & Associates, PA to release all or any portion of my records, including x-rays or lab results, and to discuss the details of my medical condition with the following family members

|  |  |
| --- | --- |
| NAME | RELATIONSHIP |
|  |  |
|  |  |
|  |  |
|  |  |

Communicating with the patient can be done by (check the appropriate blocks)

|  |  |  |
| --- | --- | --- |
| METHOD | YES | NO |
| Messages left at home phone number on machine |  |  |
| Messages left at home phone number with a person |  |  |
| Messages left at work phone number on machine |  |  |
| Messages left at work phone number with a person |  |  |
| Messages left at cell phone number |  |  |
| Email |  |  |
| Fax |  |  |

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

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_