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.

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.

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

The attorneys should send the completed form to the doctor.

Patient Questionnaire Name _____ Date _____

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)

Employer From-To (Month/Year)	Type of work	Reason for leaving	Injury on job? (Yes or No)	If Injury on Job: Settlement given ? (Yes or No)	If Injury on Job: Percent Disability awarded

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 ☐ Divorced ☐ Co-habitate ☐ Widowed ☐ Married	
		☐ Single ☐ Divorced ☐ Co-habitate ☐ Widowed ☐ Married	
		☐ Single ☐ Divorced ☐ Co-habitate ☐ Widowed ☐ Married	
		☐ Single ☐ Divorced ☐ Co-habitate ☐ Widowed ☐ Married	
		☐ Single ☐ Divorced ☐ Co-habitate ☐ Widowed ☐ Married	
		Total Children	

2) Hobbies

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

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)

3) Allergies

Allergy	From (Year)	To (Year)	Pre-injury (check if YES)	Post-injury (check if YES)

4) Immediate Relatives (Father, Mother, Brothers, Sisters)

Relationship	Living (Check if YES)	Age at Death	Year of Death	Cause of Death
Father				
Mother				

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				

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											
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

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

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 _____