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 ☐ 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)

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.

P. Brent Koprivica, MD & Associates, P.A.

10127 W. Leavenworth Road, Kansas City, KS 66109

HIPAA MEDICAL RELEASE FORM

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

My Name:_____ My Address:_____

My Phone No.:_____ City/State/Zip_____

I authorize P. Brent Koprivica, MD and Associates, PA, to disclose in any method my Protected Health Information to my Employer; its Workers' Compensation Insurance Carrier; their agents, attorneys, and representatives; my legal representatives; other healthcare providers, and the following people:

Name	Relationship

I further authorize attempted communications with me can be accomplished by the following checked methods:

Description	YES
Telephone at my home or cell phone number with a person who answers or by a message to voice mail or answering machine.	
My Email address of:	
My Fax :	
Other (please designate):	

Information to be released: (Check as applicable)

_____ENTIRE RECORD, all information **except** the following if checked): ____Sexually Transmitted Disease; ____HIV/AIDS; ___Other Communicable Diseases; ____Genetic Testing; ____Psychiatric/Mental Health; ____Developmental/Behavioral; ____Child/Adult Abuse/Neglect; ____Drug/Alcohol Treatment.

The dates of service of all Protected Health Information are unlimited as to time.

The purpose of this disclosure is for workers' compensation claim purposes.

I understand that:

(1) Information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment for alcohol or drug abuse.
(2) My signature below authorizes the release of my confidential information as indicated above.
(3) The information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by applicable federal and state laws, including the Health Insurance Portability and Accountability Act of 1996.
(4) If I agree to sign this authorization, I may keep a signed copy of the form.
(5) I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition services on my decision to sign this authorization.
(6) I may revoke this authorization at any time providing I notify in writing to that effect; however, any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my right to confidentially.
(7) A photocopy of this authorization is considered acceptable in lieu of the original.

I have read and understood the terms of this Authorization, and I have had a chance to ask questions about the use or disclosure of my health information. I authorize P. Brent Koprivica, M.D. & Associates, P.A. to use or disclose my health information in the manner described above.

SIGNATURE: _____ Date: _____