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January 15, 2018

CC: Dayna Simondi
Guy Medford
Joseph Schneider

Tiffany Anderson
PO Box 477
Lodi, CA 95241

Re: Medical Legal Evaluation for Tiffany Anderson

Dear Mrs. Anderson:

Your medical evaluation appointment is scheduled as follows:
El horario de su evaluacion medica, es el siguiente:

Doctor: Dr. Michael Bronshvag,
Date/Fecha: Wednesday, February 07, 2018,
Time/Hora: 11:30 AM,
Place/Lugar:

3555 Deer Park Drive, Suite 150
Stockton, CA 95219

If you have any questions or are unable to keep this appointment,
Si usted tiene alguna pregunta o no puede asistir a esta cita,

Please call 800-458-1261. There is a charge for late cancellation
Por favor llame al 800-458-1261, Hay un cargo por cancelacion

and missed appointments of $400 within 6 business days of the appointment.
Tardia y se perdio las citas de $400 dentro de los 6 dias habiles antes de la fecha de cita.

Sincerely/Sinceramente,

Appointment Coordinator/Cordinador de la cita

Enclosures: Letters of Instruction (as required by certain doctors)
Cartas de instrucciones (por ciertos medicos)
Forms – to be completed BEFORE your appointment (as needed)
Formas – Deben llenarse ANTES de venir a su cita (necessarias)

Brandshvag

PATIENT QUESTIONNAIRE, Page One

NAME _____ Date of Birth _____
Age _____; Height _____; Weight _____; SEX: Male _____
Today's Date _____ Female _____
Current Address: _____ Phone #: _____
_____

1. What is your main/most serious medical problem? _____
_____
When did it begin? _____
What caused it? _____
Did you have this illness or condition previously? _____
What treatment are you receiving? _____
_____

2. What other medical problems do you suffer from? _____
_____

3. What *medicines* (drugs, pills) do you take? Please list *NAMES & DOSES* (how often) _____
_____
_____

4. Do you have difficulty with: (please CHECK and DESCRIBE below)

_____ Lungs (cough, breathing)	_____ Kidneys, urine, bladder	_____ Eyes
_____ Heart (disease, pain)	_____ Liver, cirrhosis	_____ Ears
_____ High blood pressure	_____ Stomach, bowels	_____ Skin
_____ Diabetes	_____ Weight loss	_____ Cancer
_____ Circulation	_____ Blood, anemia	_____ Hormones
_____ Brain, nerves	_____ Mood, emotion, behavior	_____ Memory

COMMENT: _____
_____

5. Do you suffer with arthritis (joint disease or problems)? YES ___ NO ___ MAYBE ___
Do you suffer from: Pain, stiffness, muscle spasm, trouble moving, weakness, other:
DESCRIBE: _____
WHERE do you have problems? (Please CIRCLE): Back (upper and lower), head, neck, shoulders, arms, hands, spine, pelvis, hips, legs, feet, other: _____
_____
DO YOU HAVE PROBLEMS WITH: (Please CIRCLE): Lying down, sitting, standing, walking, climbing, lifting, bending, reaching, crouching, stooping, kneeling, balancing? _____
_____

6. Do you suffer from emotion or psychological problems? _____
IF YES, are you troubled by: (please CIRCLE): Nervousness; depression; bad thoughts; trouble sleeping; crying spells; suicidal worries; hallucinations (voices); poor appetite
COMMENT: _____
Are you receiving psychiatric care? _____
Where, from whom? _____
Have you required psychiatric hospitalization? _____
When, where? _____
What caused your emotional difficulty (illness, pressure, alcohol, etc.)? _____

7. What serious injuries have you had? _____
_____

8. What major operations have you had? (Please list OPERATION and YEAR) _____
_____
_____

9. What hospitalization have you had in the last five years? (Please list YEAR and REASON)
_____
_____
_____

10. Who are your regular doctors: _____
_____

PLEASE TURN TO PAGE TWO

11. What diseases run in your family? _____

12. What (if anything) are you allergic to (drugs, metals, etc.)? _____

13. How much do you smoke? _____
How much do you drink (alcohol)? _____
Do you use any drugs? _____

14. In what state or country were you born? _____
How long have you lived in California? _____
What is your marital status? (married, single, etc.) _____

15. How much education have you had? _____
Do you read and write well? _____
What are your occupational skills? _____

15A. List your work history for the past 10 years _____

16. Are you able to work at the present time? _____
If you can, at what? _____
If not, why not? _____

17. Do you require CRUTCHES, A CANE OR A BRACE? _____

18. Do you have a valid driver's license? _____

19. Are you RIGHT HANDED? _____; LEFT HANDED? _____; BOTH? _____

20. What is the most you can walk on the level without stopping?
_____ less than one block? _____ one to four blocks? _____ five or more blocks?
What makes you stop (pain, shortness of breath, tired, dizzy, other)? _____

21. What is the most you can climb without stopping?
_____ 2 steps or less _____ 10-19 steps (one flight)
_____ 3-9 steps _____ 20 steps or more
What makes you stop? _____

22. What is the most you can lift?
_____ 10 pounds or less _____ 21-40 pounds
_____ 11-20 pounds _____ more than 40 pounds
What limits you? _____

23. Have you had to GIVE UP any activities (job, sports, hobbies) because of your illness/injuries? YES____ NO____
If yes, which ones? _____

24. Are you able to vacuum _____; wash car _____; carry grocery sacks_____; do yard-lawn work _____
play sports _____
Comment: _____

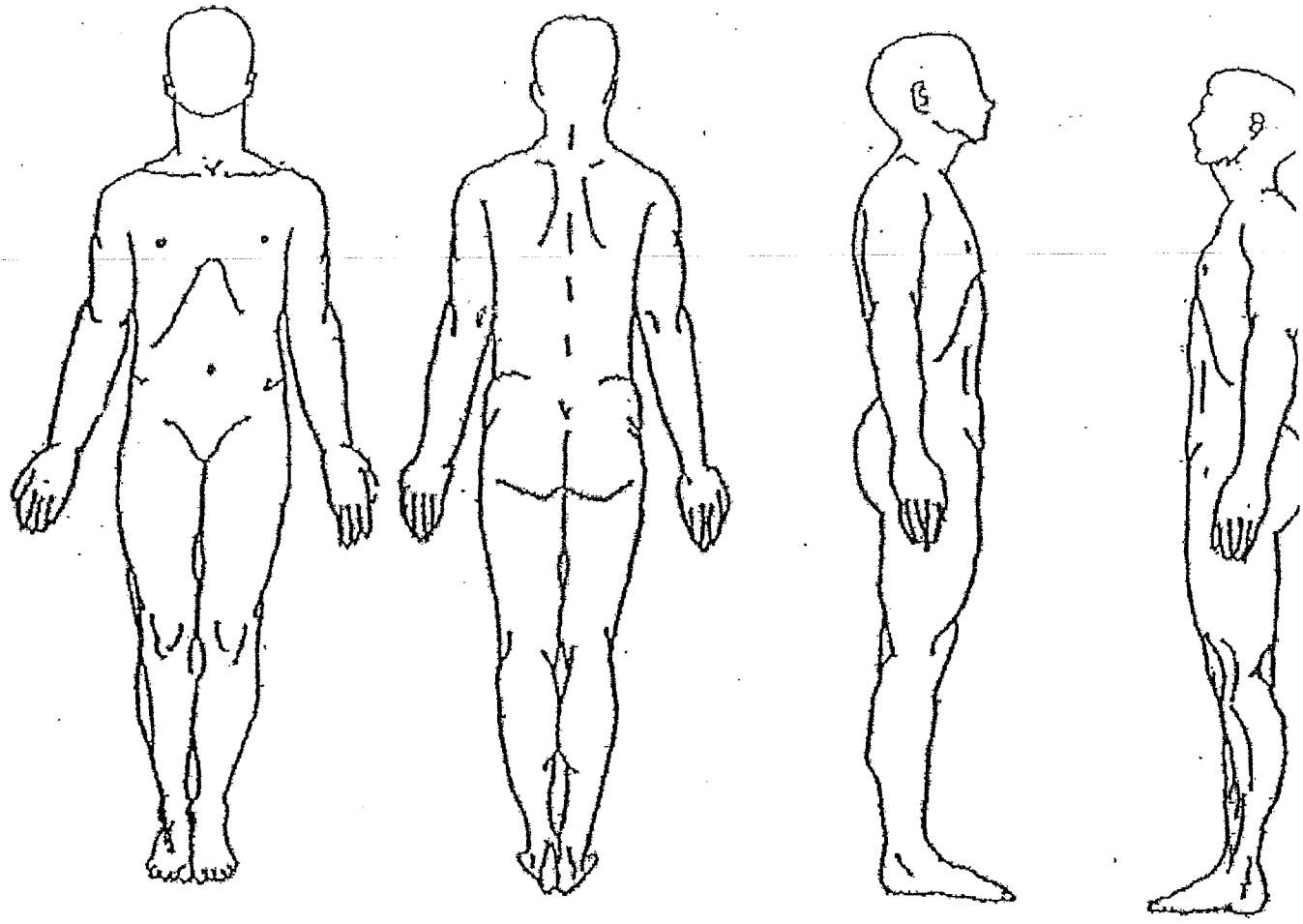
25. Do you require a special diet? (Please list DIET and REASON) _____

26. If you are disabled, is it due to (CHECK ONE OR SEVERAL)
_____ Health problems _____ Physical problems _____ Emotional problem
_____ Nervous problems _____ Family problems _____ Personal problems

Who actually filled out this form?
_____ Self; _____ Nurse; _____ Family member or friend; _____ Interpreter

Do you have any questions for us? If so, please ask receptionist or doctor.

THANK YOU AGAIN



Please indicate using XXX marks on the above drawings the distribution of your present pain.

DATE_____ **NAME**_____

Questions Concerning Activities of Daily Living (ADL)

Please fill out this form carefully and mark only one box for each question.

1. How well can you perform personal self care activities including washing, dressing, using the bathroom, etc.?

- ❑ I can look after myself normally without having extra discomfort
- ❑ I can look after myself normally but have extra discomfort
- ❑ It is uncomfortable to look after myself and I am slow and careful
- ❑ I need some help but I manage most of my personal self care
- ❑ I need help everyday in most aspects of my personal self care
- ❑ I do not get dressed, I wash with difficulty and I stay in bed or lay down most of the day

2. How well can you lift and carry?

- ❑ I can lift and carry heavy objects without having extra discomfort
- ❑ I can lift and carry heavy objects but I get extra discomfort
- ❑ I can lift and carry heavy objects only if they are conveniently positioned
- ❑ I can only lift and carry light to medium objects if they are conveniently positioned
- ❑ I can only lift very light objects
- ❑ I cannot lift or carry anything at all

3. How well can you walk?

- ❑ I am able to walk the same distance I could before my injury
- ❑ My injury and discomfort prevents me from walking more than 1 mile
- ❑ My injury and discomfort prevents me from walking more than 1/2 mile
- ❑ My injury and discomfort prevents me from walking more than 1/4 mile
- ❑ Because of my injury and discomfort I walk only a limited distance or I use a cane, crutches or walker
- ❑ Because of my injury and discomfort I am in bed most of the time or use a wheelchair

4. What is the most strenuous level of activity that you can do for at least 2 minutes?

- ❑ Very heavy activity
- ❑ Heavy activity
- ❑ Moderate activity
- ❑ Light activity
- ❑ Very light activity
- ❑ Extremely light to no activity

5. How well can you climb one flight of stairs?

- ❑ No difficulty (and you can easily perform the activity)
- ❑ Some difficulty (but you can still perform the activity well enough)
- ❑ A lot of difficulty (but you can still do the activity)
- ❑ Unable (you cannot do this activity or someone else helps you with it)

6. How well can you sit for 30 minutes to an hour?

- ❑ No difficulty (and you can easily perform the activity)
- ❑ Some difficulty (but you can still perform the activity well enough)
- ❑ A lot of difficulty (but you can still do the activity)
- ❑ Unable (you cannot do this activity or someone else helps you with it)

7. How well can you sit for two hours?

- ❑ No difficulty (and you can easily perform the activity)
- ❑ Some difficulty (but you can still perform the activity well enough)
- ❑ A lot of difficulty (but you can still do the activity)
- ❑ Unable (you cannot do this activity or someone else helps you with it)

8. How well can you stand or walk 30 minutes to an hour?

- ❑ No difficulty (and you can easily perform the activity)
- ❑ Some difficulty (but you can still perform the activity well enough)
- ❑ A lot of difficulty (but you can still do the activity)
- ❑ Unable (you cannot do this activity or someone else helps you with it)

9. How well can you stand or walk for two hours?

- ❑ No difficulty (and you can easily perform the activity)
- ❑ Some difficulty (but you can still perform the activity well enough)
- ❑ A lot of difficulty (but you can still do the activity)
- ❑ Unable (you cannot do this activity or someone else helps you with it)

10. How well can you reach and grasp something off a shelf at eye level?

- ❑ No difficulty (and you can easily perform the activity)
- ❑ Some difficulty (but you can still perform the activity well enough)
- ❑ A lot of difficulty (but you can still do the activity)
- ❑ Unable (you cannot do this activity or someone else helps you with it)

11. How well can you reach and grasp something off a shelf overhead?

- ❑ No difficulty (and you can easily perform the activity)
- ❑ Some difficulty (but you can still perform the activity well enough)
- ❑ A lot of difficulty (but you can still do the activity)
- ❑ Unable (you cannot do this activity or someone else helps you with it)

12. Do you have any difficulty with pushing and pulling activities?

- ❑ No difficulty (and you can easily perform the activity)
- ❑ Some difficulty (but you can still perform the activity well enough)
- ❑ A lot of difficulty (but you can still do the activity)
- ❑ Unable (you cannot do this activity or someone else helps you with it)

13. Do you have any difficulty with gripping, grasping, holding and manipulating objects with your hands?

- ❑ No difficulty (and you can easily perform the activity)
- ❑ Some difficulty (but you can still perform the activity well enough)
- ❑ A lot of difficulty (but you can still do the activity)
- ❑ Unable (you cannot do this activity or someone else helps you with it)

14. Do you have any difficulty with repetitive motions such as typing on a computer?

- ❑ No difficulty (and you can easily perform the activity)
- ❑ Some difficulty (but you can still perform the activity well enough)
- ❑ A lot of difficulty (but you can still do the activity)
- ❑ Unable (you cannot do this activity or someone else helps you with it)

15. Do you have any difficulty with forceful activities with your arms and hands?

- ❑ No difficulty (and you can easily perform the activity)
- ❑ Some difficulty (but you can still perform the activity well enough)
- ❑ A lot of difficulty (but you can still do the activity)
- ❑ Unable (you cannot do this activity or someone else helps you with it)

16. Do you have any difficulty with kneeling, bending or squatting?

- ❑ No difficulty (and you can easily perform the activity)
- ❑ Some difficulty (but you can still perform the activity well enough)
- ❑ A lot of difficulty (but you can still do the activity)
- ❑ Unable (you cannot do this activity or someone else helps you with it)

17. Do you have any difficulty with sleeping?

- ❑ I have no trouble sleeping because of my injury and discomfort
- ❑ My sleep is slightly disturbed (less than 1 hour sleepless) since my injury
- ❑ My sleep is mildly disturbed (1-2 hours sleepless) since my injury
- ❑ My sleep is moderately disturbed (2-3 hours sleepless) since my injury
- ❑ My sleep is greatly disturbed (3-5 hours sleepless) since my injury
- ❑ My sleep is completely disturbed (5-7 hours sleepless) since my injury

18. In regards to sexual activity since and because of your injury:

- ❑ It is not a problem and there has not been a change because of my injury
- ❑ It is a little less frequent because of my injury
- ❑ It is much less frequent because of my injury
- ❑ No sexual functioning because of my injury

19. In regards to your pain <u>at the moment</u>:

- ❑ I have no pain at the moment
- ❑ My pain is mild at the moment
- ❑ My pain is moderate at the moment
- ❑ My pain is severe at the moment
- ❑ My pain is the worst imaginable at the moment

20. In regards to your pain <u>most of the time</u>:

- ❑ I have no pain most of the time
- ❑ My pain is very mild most of the time
- ❑ My pain is moderate most of the time
- ❑ My pain is fairly severe most of the time
- ❑ My pain is the worst imaginable most of the time

21. How much does your injury and/or pain interfere with your ability to travel?

- ❑ None
- ❑ Some or a little of the time
- ❑ A lot or most of the time
- ❑ all of the time - I can't travel

22. How much does your injury and/or pain interfere with your ability to engage in social activities?

- ❑ None
- ❑ Some or a little of the time
- ❑ Most of the time
- ❑ All of the time - I can't engage in social activities

23. How much does your injury and/or pain interfere with your ability to engage in recreational activities?

- ❑ None
- ❑ some or a little of the time
- ❑ A lot or most of the time
- ❑ All of the time - I can't engage in recreational activities

24. How much does your injury and/or pain interfere with concentrating and thinking?

- ❑ None
- ❑ Some or a little of the time
- ❑ A lot or most of the time
- ❑ All of the time - I can't concentrate or think very clearly

25. How much as your injury and/or pain caused emotional distress with depression or anxiety?

- ❑ None (no depression or anxiety from the injury or discomfort)
- ❑ Some or a little of the time (mild depression or anxiety from the injury or discomfort)
- ❑ A lot or most of the time (moderate depression or anxiety from the injury or discomfort)
- ❑ All of the time (severe depression or anxiety from the injury or discomfort)