KAISER PERMANENTE®

Place label here

Department of Physical Medicine and Rehabilitation

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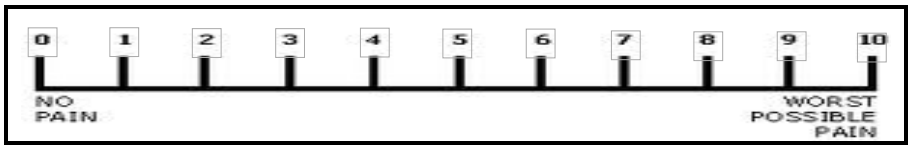
Name: _____ Date: _____

Main problem you would like addressed today? _____

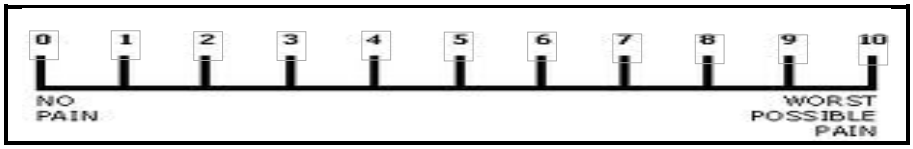
1. Approximate date pain/symptom began: _____
2. Describe in your own words how the pain started:
   _____
3. Was this work related? ☐Yes ☐No
4. Was this a worsening of an existing injury? ☐Yes ☐No
5. Have you had this pain before? ☐Yes ☐No
6. Is your pain: ☐ Continuous ☐ Intermittent
7. Where is the pain? ☐ Back ☐Neck ☐ Right arm ☐ Left Arm ☐Right leg ☐Left leg
8. How did your pain begin? (Check all that apply) ☐ Gradually ☐Suddenly ☐Bending ☐ Lifting ☐Assault ☐Car Accident ☐ Upon waking ☐Pushing/Pulling ☐ Twisting
9. What time during the day is your pain worst? ☐Morning ☐End of day ☐Night ☐Always

Circle your symptom levels:

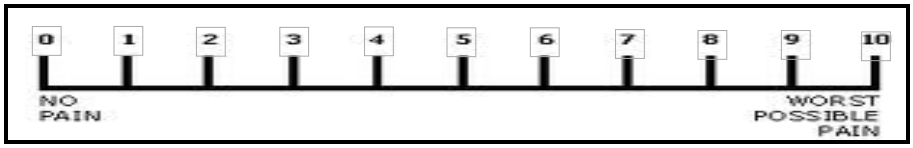
PAIN TODAY



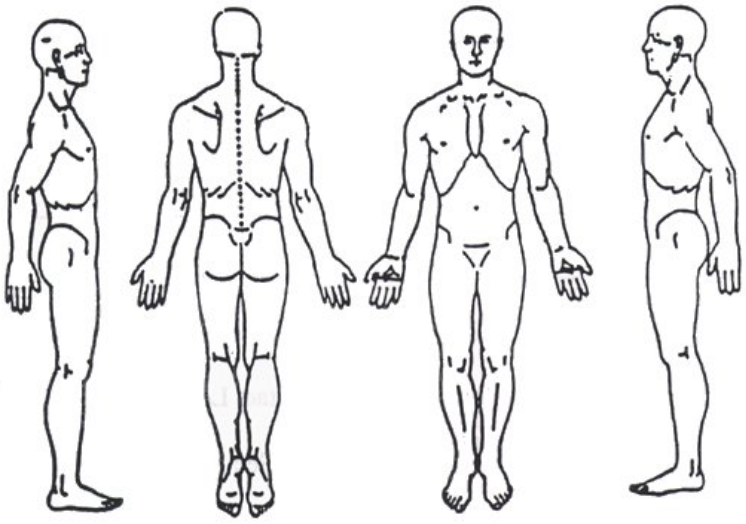
WORST PAIN IN PAST 2 WEEKS



LEAST PAIN IN PAST 2 WEEKS



*Please mark description of pain below



Right **Back** **Front** **Left**

Where does the pain hurt at this time?
☐100% Back or Neck; 0% Arm or Leg
☐ 50% Back or Neck; 50% Arm or Leg
☐ 0% Back or Neck; 100% Arm or Leg
☐ Other _____

Do you have problems urinating or moving your bowels? ☐Yes ☐No
If yes, since when? _____

Do you have arm/leg weakness?
☐Yes ☐No
If yes, which part? _____

Do you have arm/leg numbness?
☐Yes ☐No
If yes, which part? _____

Do you have sleep problems? ☐Yes ☐No

Do you exercise? ☐Yes ☐No

PAIN DIAGRAM

On the diagram to the left, please mark the exact spots where you are experiencing any of the following sensations:

(Please use only the symbols listed)

==== Numbness ○○○○ Pins and Needles
xxxx Burning >>>> Aching //// Stabbing
●●● Other, explain: _____
_____
_____

Place label here

Rate these activities on how your pain is affected:

	Better	Worse	No change
Sitting	☐	☐	☐
Standing	☐	☐	☐
Bending forward	☐	☐	☐
Bending backward	☐	☐	☐
Lying down on the back	☐	☐	☐
Lying down on stomach	☐	☐	☐
Lying on the side	☐	☐	☐
Coughing or sneezing	☐	☐	☐
Pain during menstruation	☐	☐	☐
Walking	☐	☐	☐

Rate these treatments on how your pain is affected:

	Better	Worse	No change
Heat	☐	☐	☐
Ice	☐	☐	☐
TENS unit	☐	☐	☐
Exercise	☐	☐	☐
Massage	☐	☐	☐
Chiropractic	☐	☐	☐
Physical therapy	☐	☐	☐
Spinal injection	☐	☐	☐

Spinal injection dates _____

Do you use any of the following? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other _____

Do you take any medications *not* provided by your Kaiser doctor? ☐ Yes ☐ No
If yes, which ones? _____

Do you use any drugs? ☐ Yes ☐ No
If yes, which ones? _____

WORK HISTORY

Are you:
☐ Currently working ☐ Permanent disability since _____
☐ Retired ☐ Temporary disability _____

If you are currently working, please explain the physical demands of your job:
Describe your job: _____

☐ Very heavy (lift > 100lbs) ☐ Heavy (Lift > 50 lbs.)
☐ Moderate (lift > 30 pounds) ☐ Light (Lift 15-30 lbs.)
☐ Repetitive hand tasks ☐ Sedentary (no lifting)

SOCIAL HISTORY

What is your marital status? ☐ Married ☐ Single/never married ☐ Divorced/separated ☐ Widowed
Living with? ☐ Spouse ☐ Significant other ☐ Child ☐ Alone
What are the ages of your children? 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

How many levels are in your home? ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more _____ (please list how many)
What is your highest level of education? ☐ High school/GED ☐ Some college ☐ College ☐ Trade School

SURGICAL HISTORY

Please list any surgeries you have had:
1. _____ Date:
2. _____ Date: _____
3. _____ Date:
4. _____ Date: _____

REVIEW OF SYMPTOMS

	Yes	No		Yes	No		Yes	No		Yes	No
Fever	☐	☐	Weight loss	☐	☐	Diabetes	☐	☐	Depression	☐	☐
Heart attack	☐	☐	Blood in stool	☐	☐	Cancer	☐	☐	Kidney problem	☐	☐
Bleeding problem	☐	☐	Bowel incontinence	☐	☐	Bladder incontinence	☐	☐	Vision problems	☐	☐
Asthma/COPD	☐	☐	Ankle swelling	☐	☐	Balance problems	☐	☐	High BP	☐	☐
Constipation	☐	☐	Joint aches	☐	☐	Fatigue	☐	☐	Liver problem	☐	☐

_____ _____
Signature Date