KAISER PERMANENTE®

Department of Physical Medicine and Rehabilitation

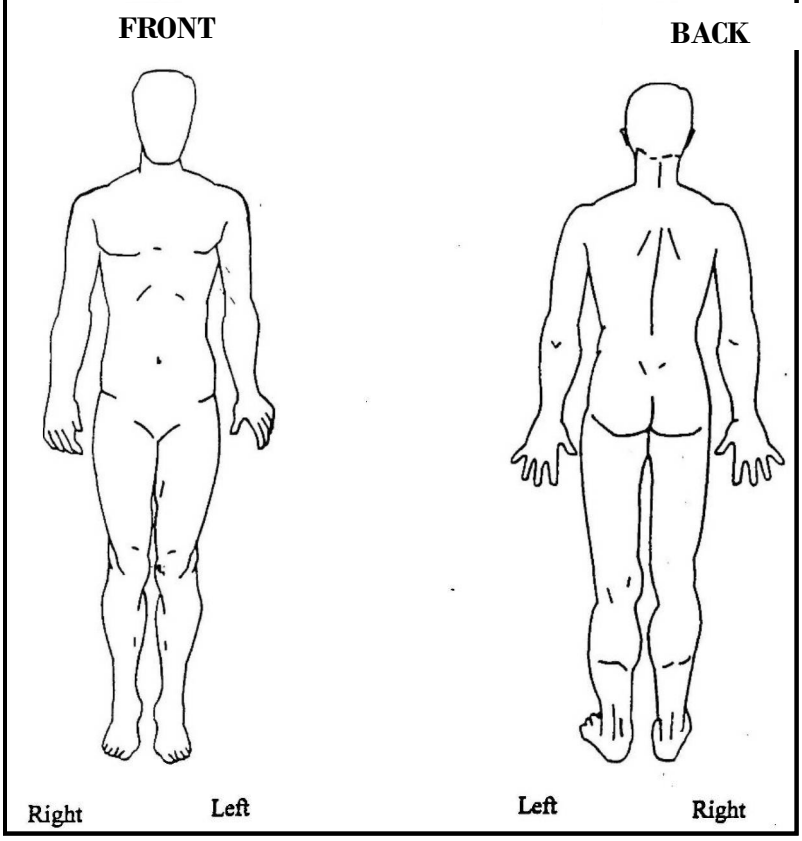
2120 Professional Drive, Suites 135 & 225, Roseville, CA 95661 916-771-6611
2025 Morse Avenue, Station 2C, Sacramento, CA 95825 916-973-7481

Name: _____ **Main problem**: _____

When did the main problem **start**? _____

What **caused** your main problem? _____

Please place "XX" on the diagram below where you are experiencing pain.
Please place "OO" on the diagram below where you are experiencing numbness/tingling



Circle the **lowest** and **highest** pain level during the **last week**

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Describe Your Pain:

☐ Throbbing ☐ Gnawing
☐ Shooting ☐ Heavy
☐ Stabbing ☐ Tender
☐ Sharp ☐ Burning
☐ Cramping ☐ Splitting

What positions or activities make your pain **worse**?

☐ Sitting Other ☐
☐ Standing
☐ Walking
☐ Laying _____

What positions or activities make your pain **better**?

☐ Sitting Other ☐
☐ Standing
☐ Walking
☐ Laying

Do you have any of the following?

Fevers, chills, or night sweats	☐ Yes	☐ No	
Recent unintended weight loss	☐ Yes	☐ No	
Incontinence (loss of bladder or bowel control)	☐ Yes	☐ No	
Groin (genital region) numbness	☐ Yes	☐ No	
Is today's problem related to an on-the-job injury?	☐ Yes	☐ No	☐ Unsure
Have you filed a claim for today's problem with your employer?	☐ Yes	☐ No	
Is today's problem related to a personal injury case or motor vehicle accident?	☐ Yes	☐ No	☐ Unsure
Do you have or anticipate litigation (lawsuit) regarding today's problem?	☐ Yes	☐ No	☐ Unsure

What have you tried for your symptoms?
Check all that apply and circle those that helped.

☐ Physical therapy ☐ Back Class ☐ Acupuncture ☐ Braces ☐
☐ Chiropractic ☐ Traction ☐ Yoga ☐ Pilates ☐
☐ Chronic Pain Program ☐ Spine injections ☐ ☐ Inversion Table ☐
☐ "Managing Your Back Pain" video ☐
☐ Spine surgery (list dates) ☐ _____
☐ Other ☐ _____

How many **total** minutes in one week do you exercise? _____

What do you do for exercise?
☐ Walking program ☐ Jogging ☐ Bicycling
☐ Exercise classes ☐ Exercise machines ☐ Swimming
☐ Other (please list) _____

Please check any psychiatric or psychological problems that you have experienced:
☐ Depression ☐ Anxiety ☐ Bipolar ☐ ADD/ADHD
☐ PTSD ☐ OCD ☐ Emotional, physical, or sexual abuse
☐ Other _____

What type of work do/did you do? _____

What is your current employment status?
☐ Working full-time ☐ Working part-time ☐ On modified work
☐ On sick leave ☐ Unemployed ☐ Disabled
☐ Retired

Over the last two weeks, how often have you been bothered by any of the following problems? (Circle only one number per line)	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things	0☐	1☐	2☐	3☐
2. Feeling down depressed or hopeless	0☐	1☐	2☐	3☐
3. Feeling nervous, anxious or on edge	0☐	1☐	2☐	3☐
4. Not being able to stop or control worrying	0☐	1☐	2☐	3☐