KAISER PERMANENTE®

Please fill out this form and bring it to the appointment.

Name: _____

MR #: _____

IMPRINT AREA

CONFIDENTIAL PATIENT HISTORY QUESTIONNAIRE

PLEASE PRINT LEGIBLY IN BLACK INK. CHECK, CIRCLE AND FILL IN BLANKS THAT APPLY TO YOU.

NAME					ADDRESS
HOME PHONE			WORK PHONE		
AGE	HT	WT	SEX	DOMINANT HAND	
			☐ Male ☐ Female	☐ Right ☐ Left	

Where is the main pain problem for which you were referred?
☐ Neck ☐ Back ☐ Arm: R L ☐ Leg: R L

Approximate date this pain began: _____

How did it begin? (Check all that apply.)
☐ Woke up with it ☐ Pushing/Pulling ☐ Twisting
☐ Bending ☐ Lifting ☐ Assault
☐ Car Accident ☐ Gradually ☐ Suddenly
☐ Other: _____

Was this work related? ..... ☐ Yes ☐ No

Was this a worsening of an old injury? ..... ☐ Yes ☐ No

Current distribution of pain complaints:
☐ 100% Back or Neck; 0% Arm or Leg
☐ 50% Back or Neck; 50% Arm or Leg
☐ 0% Back or Neck; 100% Arm or Leg

Do you have arm/leg weakness? ..... ☐ Yes ☐ No

Do you have arm/leg numbness? ..... ☐ Yes ☐ No

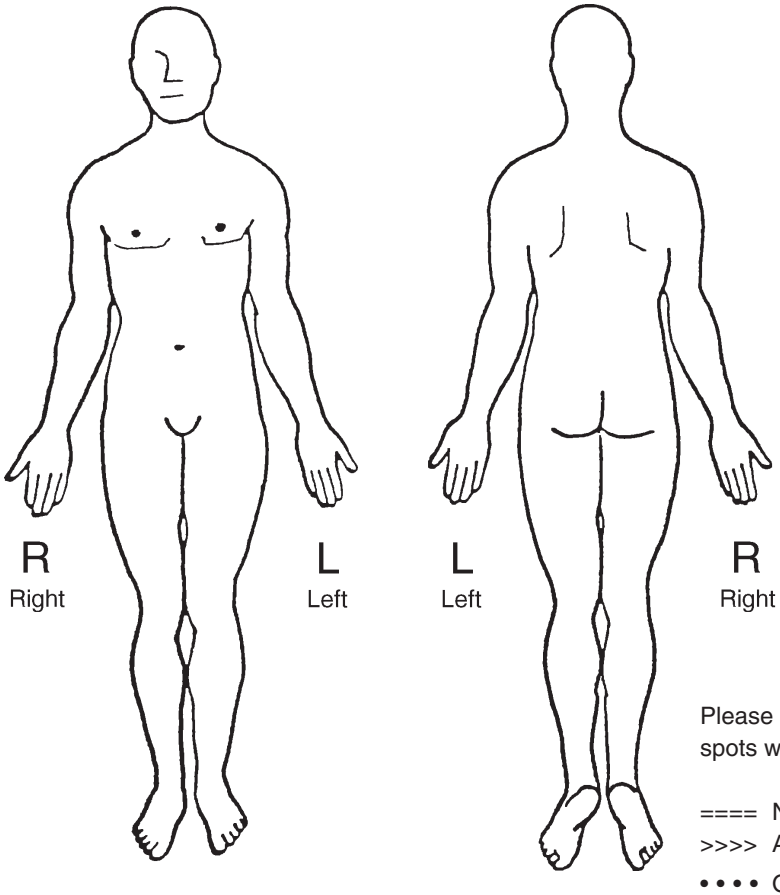
Is your pain:
☐ Continuous ☐ Intermittent

When is your pain worst?
☐ Morning ☐ End of the Day ☐ Night

Does walking make your pain worse? ..... ☐ Yes ☐ No
If yes, is this pain in your legs? ..... ☐ Yes ☐ No

Does coughing or sneezing increase your pain? ..... ☐ Yes ☐ No

Do you have problems urinating or moving your bowels? ..... ☐ Yes ☐ No



Describe in your own words how this pain started.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Pain Diagram

Please note the orientation of the diagrams below and mark the exact spots where you are experiencing any of the following sensations.
(Please use only the symbols listed.)

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

_____

Rate your pain on this scale. (Mark with an X)

0 = No Pain 10 = Worst possible pain

PAIN TODAY

0 ——|——|——|——|——|——|——|——|——|——|—— 10

LEAST PAIN IN LAST 2 WEEKS

0 ——|——|——|——|——|——|——|——|——|——|—— 10

WORST PAIN IN LAST 2 WEEKS

0 ——|——|——|——|——|——|——|——|——|——|—— 10

Rate these activities on how your pain is affected:

	Better	Worse	No Difference
Sitting	☐	☐	☐
Standing	☐	☐	☐
Bending Forward	☐	☐	☐
Bending Backward	☐	☐	☐
Lying Flat on Back	☐	☐	☐
Lying Flat on Stomach	☐	☐	☐
Lying Flat on Side	☐	☐	☐

Who else has treated you for this?

☐ Physical Therapist ☐ Chiropractor

☐ Other: _____

Rate these treatments on how your pain is affected:

	Better	Worse	No Difference
Heat	☐	☐	☐
Ice	☐	☐	☐
TENS Unit	☐	☐	☐
Exercise	☐	☐	☐
Manipulation	☐	☐	☐
Traction	☐	☐	☐

Do you do back/neck exercises? ..... ☐ Yes ☐ No

Do you do them daily? ..... ☐ Yes ☐ No

Do you do aerobic exercise regularly? ..... ☐ Yes ☐ No

Do you have any sleep problems? ..... ☐ Yes ☐ No

If yes: How many hours do you sleep? _____

How many times do you awaken a night? _____

PREVIOUS BACK/NECK INJURY HISTORY

Have you ever had this exact injury before? ☐ Yes ☐ No

If yes, did you have surgery? ..... ☐ Yes ☐ No

Have you ever had a back problem before? .. ☐ Yes ☐ No

Have you ever had a motor vehicle accident? . ☐ Yes ☐ No

If yes, how many? _____

Was there litigation (lawyers) involved? ..... ☐ Yes ☐ No

Have you ever filed a Workers' Comp claim? .. ☐ Yes ☐ No

What part of the body was hurt? _____

Was there litigation (lawyers) involved? ..... ☐ Yes ☐ No

Have you ever missed any work from a back or neck problem? ..... ☐ Yes ☐ No

If yes, how much time? _____

Have you ever had back or neck surgery? .... ☐ Yes ☐ No

Date	Type of Surgery	Pain Better Afterward	Pain Worse Afterward

WORK HISTORY

Are you:

☐ Currently Working ☐ Permanently Disabled

☐ Retired ☐ Temporarily Disabled

Did you stop working because of your pain? .. ☐ Yes ☐ No

Current/Recent Employer: _____

Date of Hire: _____

Usual Occupation: _____

Physical Demands of Your Job

☐ Very Heavy (lift >100 lbs.) ☐ Heavy (lift > 50 lbs.)

☐ Moderate (lift > 30 lbs.) ☐ Light (lift 15-30 lbs.)

☐ Repetitive Hand Tasks ☐ Sedentary (No lifting)

Describe your job.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY

Marital Status

	HOW MANY TIMES?	HOW LONG?
☐ Married		
☐ Divorced		
☐ Separated		
☐ Widowed		
☐ Live with significant other		
☐ Never Married		

How many children do you have and what are their ages?

1.____ 2.____ 3.____
4.____ 5.____ 6.____
7.____ 8.____ 9.____
10.____ 11.____ 12.____

Habits: (Check if you have or have ever had the following habits.)

☐ Smoking Cigarettes: Age started ____ # of packs/day ____
☐ Quit: ____ (when)
☐ Cigars ☐ Marijuana ☐ Crank
☐ Pipe ☐ Cocaine ☐ Heroin
☐ Caffeinated Beverages (Coffee, tea, cola) # per day ____
☐ Drinking Alcoholic Beverages: Age started ____
Last drink ____ (when) # of drinks/week ____
☐ Have you tried alcohol to help your pain? .... ☐ Yes ☐ No

EDUCATION:
What is your highest level of education or training?

GENERAL MEDICAL HISTORY

Who is your Primary Care Doctor?

Who referred you to us?

When was your last general physical?

When was your last rectal exam?

FEMALES:
When was your last pelvic exam, Pap smear, breast exam?

What were the results?

Check if you have or had any of these medical problems:

☐ Heart Attack/Angina ☐ High Blood Pressure
☐ Stroke ☐ Diabetes
☐ Ulcers ☐ Thyroid Disease
☐ Kidney Disease ☐ Liver Disease
☐ Arthritis
☐ Cancer (type: ____)

LIST ALL SURGERIES AND DATES (not spine related)

Type of Surgery	Date	Type of Surgery	Date

LIST ALL DRUG ENVIRONMENTAL AND FOOD ALLERGIES

LIST ALL MEDICATIONS YOU TAKE (Including nonprescription. {Check those meds that you take for your back/neck.}**)**

Medication	Dosage	Medication	Dosage
☐		☐	
☐		☐	
☐		☐	
☐		☐	
☐		☐	
☐		☐	
☐		☐	

GENERAL SYMPTOMS

During the past year, have you had any of the following symptoms?

Symptom:	**Explanation:**
☐ Persistent Fevers	
☐ Night Sweats	
☐ Weight Loss (more than 10 lbs.)	
☐ Multiple Joint Ache	
☐ Sleep Problems	
☐ Fatigue	
☐ Depression	
☐ Easy Bruising	
☐ Excessive Bleeding	
☐ Persistent Diarrhea	
☐ Constipation	
☐ Swollen Ankles	
☐ Dark Stools	
☐ Blood In Stool	
☐ Difficulty Urinating	
☐ Incontinence	
Females:	**Explanation:**
☐ Excessive Vaginal Bleeding	
☐ More Back/Neck Pain With Periods	

Is there anything else we should know that could help us take care of you?

To the best of my knowledge, all of the above is true.

SIGNATURE	DATE