KAISER PERMANENTE

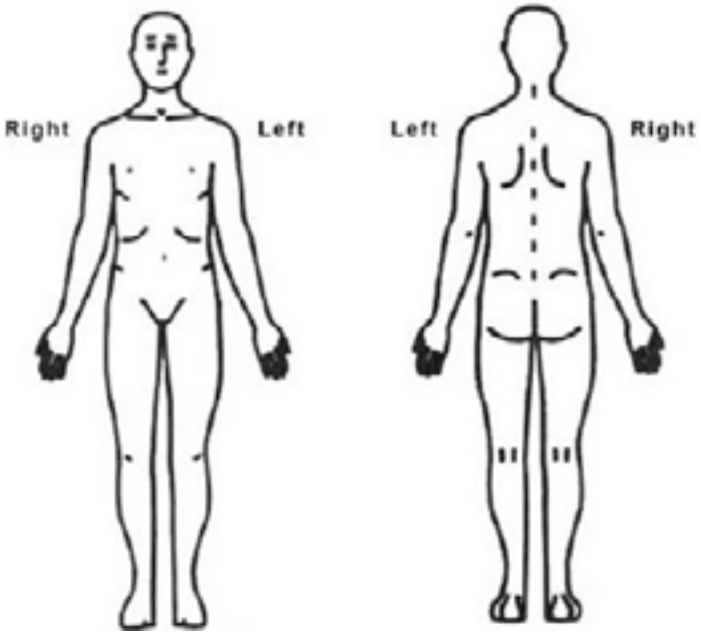
Physical Medicine and Rehabilitation Department
801 Traeger Avenue, 2nd Floor
San Bruno, CA 94066
Phone #: (650) 742-7226

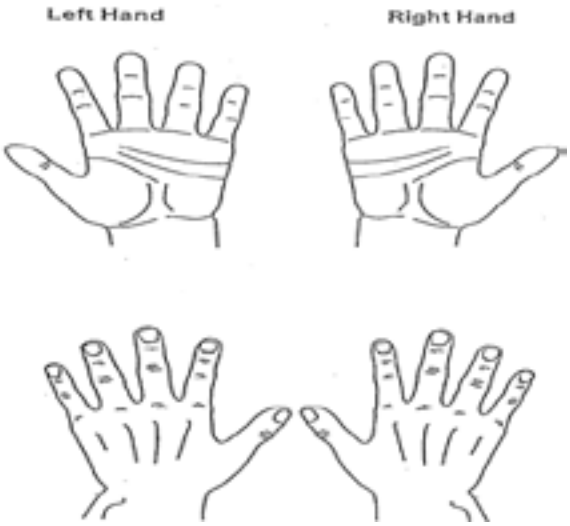
Date:_____

Medical Record #:_____

Name:_____

PAIN DIAGRAM (Please use a pen)





Dominant Hand: Left or Right (circle)

DRAW YOUR PAIN:
On the diagrams above, use a pen mark in the areas where you feel pain/numbness:
X = pain O = numbness

Please rate your pain by selecting the number in the scale below and mark it with an **X**

0= No Pain 10= Worst Possible Pain

PAIN TODAY

0	1	2	3	4	5	6	7	8	9	10

LEAST (pain in the last 2 weeks)

0	1	2	3	4	5	6	7	8	9	10

WORST (pain in the last 2 weeks)

0	1	2	3	4	5	6	7	8	9	10

LIST ALL DRUG, ENVIRONMENTAL, AND FOOD ALLERGIES:

_____
_____
_____
_____

LIST ALL MEDICATIONS YOU TAKE (including non-prescription). Check the box for those meds that you take for this problem.

	Medication	Dosage
☐	_____	_____
☐	_____	_____
☐	_____	_____
☐	_____	_____
☐	_____	_____
☐	_____	_____
☐	_____	_____
☐	_____	_____
☐	_____	_____

Name:_____ Medical Record #:_____

Our main goal is to provide you with excellent care and service at all times. We would like some information about your needs today so that we may respond to them directly.

What are the main problems that you want help with?

1. _____
2. _____

Please list the most important questions and concerns you would like answered today.

1. _____
2. _____
3. _____

In order that we may be familiar and up-to-date with any recent changes in your medical history, please provide the following information:

Chronic medical conditions:

_____

_____

New medical conditions:

_____

_____

_____

Cigarettes: O Yes O No Packs/day_____

Alcohol: O Yes O No Drinks/day_____

O Married O Single O Widowed O Divorced

Years with Employer?_____ Primary physician at KP:_____

Have you ever filed a work injury claim before? O Yes O No

If yes, when?_____

What type of injury?_____

Who sent you here today? O Employer O Physician O Self