KAISER PERMANENTE®

Patient Label

Physical Medicine & Rehabilitation/Pain New Patient Questionnaire

Name: _____ Date: _____

What is your main problem and what questions would you like to talk about today?_____
_____

When and how did the problem start? _____

If you have pain, do certain activities or positions (such as sitting, standing, lying down) make the pain better or worse? Please explain: _____
_____
_____

Family history: Check any medical problems that your grandparents, parents, brothers or sisters have or had:
☐ Depression or other psychiatric problems ☐ Nervous system disorders ☐ Addiction problems
☐ Pain problems ☐ Other: _____

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No Do you use drugs? ☐ Yes ☐ No

How often have you used marijuana in the last year?_____
How often have you used recreational drugs (such as heroin, cocaine, or methamphetamine) or used a prescription medicine for non-medicinal purposes in the last year?_____

What is your occupation? _____

How much work have you missed because of this problem? _____

What is your living situation? ☐ Live alone ☐ Live with spouse or significant other ☐ Live with family
☐ Have live-in help ☐ Live in skilled nursing facility or adult family home ☐ Have support nearby
How many levels is your home? ____ Are there steps to enter? ☐ Yes ☐ No Other barriers:_____

Hobbies, social activities, exercise, what you like to do for fun? _____
_____

Have you had any of the following symptoms in the last 30 days? (Please check all that apply.)

General
☐ Fever
☐ Weight loss
☐ Weight gain
☐ Loss of appetite
☐ Problems sleeping or staying asleep
☐ Fall asleep too easily

Eyes, Ears, Nose, Mouth &Throat
☐ Double vision
☐ Blindness one/both eyes
☐ Loss of hearing
☐ Loss of smell
☐ Difficulty swallowing
☐ Dental problems

Cardiovascular
☐ Heart racing/irregularities
☐ Heart murmur
☐ Chest pain
☐ Ankle swelling

Respiratory
☐ Shortness of breath
☐ Cough
☐ Snoring

Gastrointestinal
☐ Nausea
☐ Abdominal pain
☐ Change in bowel movement
☐ Loss of bowel control
☐ Constipation

Genitourinary
☐ Urinary urgency
☐ Having to urinate often at night
☐ Loss of bladder control
☐ Difficulty urinating

Musculoskeletal
☐ Joint redness or swelling
☐ Muscle tenderness
☐ Pain with movement
☐ Morning stiffness

Skin
☐ Dry skin
☐ Rash
☐ Itching
☐ Ulcer/wounds
☐ Breast swelling or lump

Neurologic
☐ Numbness or tingling
☐ Weakness
☐ Memory problems
☐ Confusion
☐ Difficulty walking or stumbling
☐ Falling
☐ Clumsiness
☐ Leg pains when walking
☐ Headache

Mental Health
☐ Depression
☐ Anxiety
☐ Stress in home/work life

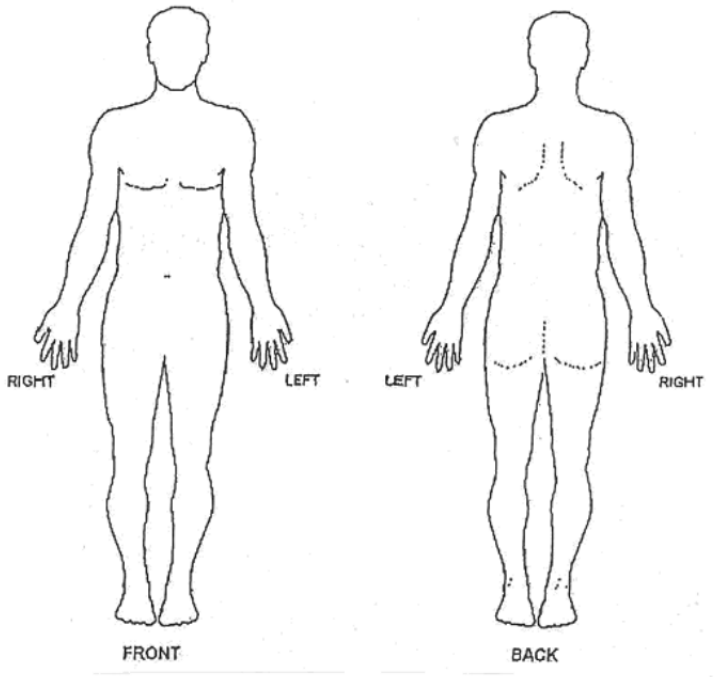
Endocrine
☐ Increased thirst
☐ Problems with sexual function

Continued on next page

Pain Diagram

Please use these symbols to mark where you have any of the following symptoms on the diagram below:

Numbness/tingling	- - - - -
Achy pain	xxxxx
Sharp pain	/////////



Pain and Functional Scale

1. What number best describes your pain on average in the past week:

   0 1 2 3 4 5 6 7 8 9 10

   No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

   0 1 2 3 4 5 6 7 8 9 10

   Does not Interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

   0 1 2 3 4 5 6 7 8 9 10

   Does not Interfere — Completely interferes