KAISER PERMANENTE®

Kaiser Permanente Richmond
Interventional Physiatry Service
901 Nevin Avenue
Richmond, California 94801

MR #: ____________________

Name: ____________________

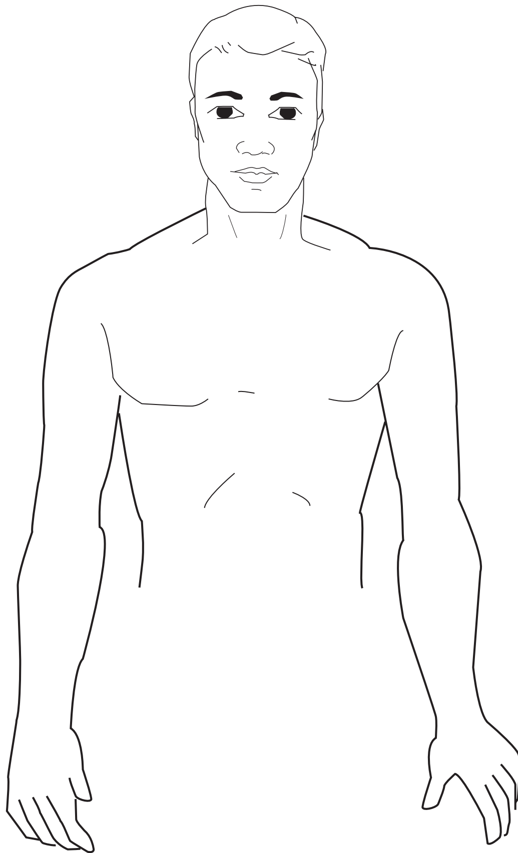
IMPRINT AREA

CONFIDENTIAL CERVICOTHORACIC FOLLOW-UP QUESTIONNAIRE

PAIN DIAGRAM – *Please answer each question*

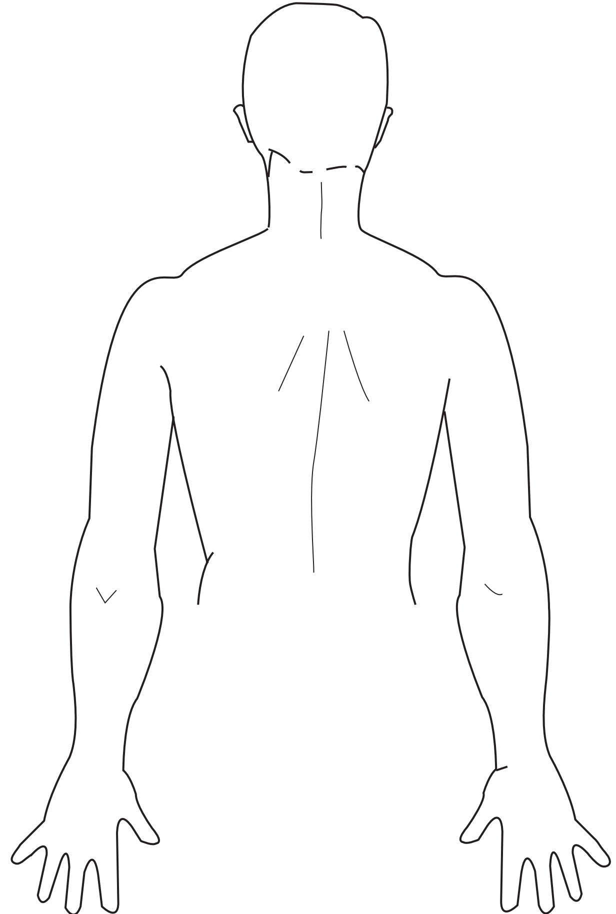
Please place X's on the diagram below where you are experiencing pain or numbness.

FRONT



Right **Left**

BACK



Left **Right**

My primary pain is in my: **(Check only one)**

☐ Neck / Upper Back ☐ Shoulder / Arm ☐ Forearm / Wrist ☐ Hand

What percentage of your pain is in your neck / upper back? ________%

What percentage of your pain is in your shoulder / arm / forearm / wrist? ________%

(Must equal 100%)

On a scale of 0 to 10, with zero being no pain and 10 being excruciating pain, I would rate my pain **today** as:

0 1 2 3 4 5 6 7 8 9 10

On a scale of 0 to 10, with zero being no pain and 10 being excruciating pain, I would rate my pain **over the past two weeks** as:

0 1 2 3 4 5 6 7 8 9 10

DEMOGRAPHIC DATA

NAME		KAISER MR #	
AGE	SEX	HEIGHT	WEIGHT

HPI

My chief complaint today is: ____________________

Have you been seen in this department for this problem in the past?....................... ☐ Yes ☐ No

This has been going on for:

_______ Days _______ Weeks _______ Months _______ Years

If this is a new problem, do you have any ideas or opinions on what may have caused it? ____________________

If your current problem stems from a specific injury, please describe the nature and date of the incident or accident: ____________________

OCCUPATIONL / TPL

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 (law suit) regarding today's problem? .... ☐ Yes ☐ No ☐ Unsure

MEDS

Please list your current medications: ____________________

Please list any herbs or over-the-counter medications that you are currently using: ____________________

ALLERGIES

Please list any allergies to medicine or foods that you experience: ____________________

SIGNATURE	DATE