



Santa Rosa
 Department of Occupational Medicine
 Phone: (707) 571-3000 • Fax: (707) 571-4346

Name: _____

MR #: _____

**FINAL REPORT PATIENT QUESTIONNAIRE
 PERMANENT AND STATIONARY REPORT**

IMPRINT AREA

PATIENT'S NAME	MEDICAL RECORD #	PHONE # (DAY)	PHONE # (NIGHT)
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Your appointment is with:

- Dr. Green
 Dr. Lakshmanan
 Dr. Pappas
 Dr. Vidaurri
 Dr. Weitzenberg
 Dr. Zaharoff
 at _____ on _____, Suite _____

Please bring this entire questionnaire filled out completely to your appointment. This questionnaire will allow your doctor to write a report regarding your injury and be able to describe if and how you might be different physically or functionally since this industrial injury.

1. What activities have you given up because of this injury?

HOUSEHOLD ACTIVITIES (Check only those that apply)

Other

- | | | |
|------------------------------------|--|--------------------------------|
| <input type="checkbox"/> Laundry | <input type="checkbox"/> Light cleaning | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Vacuuming | <input type="checkbox"/> Heavy cleaning (e.g., scrubbing floors) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Gardening | <input type="checkbox"/> Cooking | <input type="checkbox"/> _____ |

WORK (Check only those that apply)

Other

- | | | |
|--|--|--------------------------------|
| <input type="checkbox"/> Light lifting < 10 lbs. | <input type="checkbox"/> Light typing | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Light-Moderate lifting 10-25 lbs. | <input type="checkbox"/> Light clerical | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Moderate lifting 26-40 lbs. | <input type="checkbox"/> Repetitive hand activity (Heavy typing) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Heavy lifting 41-60 lbs. | <input type="checkbox"/> Repetitive gripping | |
| <input type="checkbox"/> Very Heavy lifting > 60 lbs. | <input type="checkbox"/> Overhead work | |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Pushing / pulling | |
| <input type="checkbox"/> Climbing | <input type="checkbox"/> Bending | |
| <input type="checkbox"/> Squatting | <input type="checkbox"/> Twisting | |

PLAY (Hobbies / Sports)

Other

- | | | | |
|----------------------------------|--|--------------------------------|--------------------------------|
| <input type="checkbox"/> Running | <input type="checkbox"/> Sewing / Knitting | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Biking | <input type="checkbox"/> Throwing sports | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

2. What activities do you now do with numbness and/or pain because of this injury?

HOUSEHOLD ACTIVITIES (Check only those that apply)

Other

- | | | |
|------------------------------------|--|--------------------------------|
| <input type="checkbox"/> Laundry | <input type="checkbox"/> Light cleaning | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Vacuuming | <input type="checkbox"/> Heavy cleaning (e.g., scrubbing floors) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Gardening | <input type="checkbox"/> Cooking | <input type="checkbox"/> _____ |

WORK (Check only those that apply)

Other

- | | | |
|--|--|--------------------------------|
| <input type="checkbox"/> Light lifting < 10 lbs. | <input type="checkbox"/> Light typing | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Light-Moderate lifting 10-25 lbs. | <input type="checkbox"/> Light clerical | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Moderate lifting 26-40 lbs. | <input type="checkbox"/> Repetitive hand activity (Heavy typing) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Heavy lifting 41-60 lbs. | <input type="checkbox"/> Repetitive gripping | |
| <input type="checkbox"/> Very Heavy lifting > 60 lbs. | <input type="checkbox"/> Overhead work | |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Pushing / pulling | |
| <input type="checkbox"/> Climbing | <input type="checkbox"/> Bending | |
| <input type="checkbox"/> Squatting | <input type="checkbox"/> Twisting | |

PLAY (Hobbies / Sports)

Other

- | | | | |
|----------------------------------|--|--------------------------------|--------------------------------|
| <input type="checkbox"/> Running | <input type="checkbox"/> Sewing / Knitting | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Biking | <input type="checkbox"/> Throwing sports | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Name: _____

MR #: _____

**REST
PERMANENT AND STATIONARY REPORT
PAIN DIAGRAM** *Please use a pen*

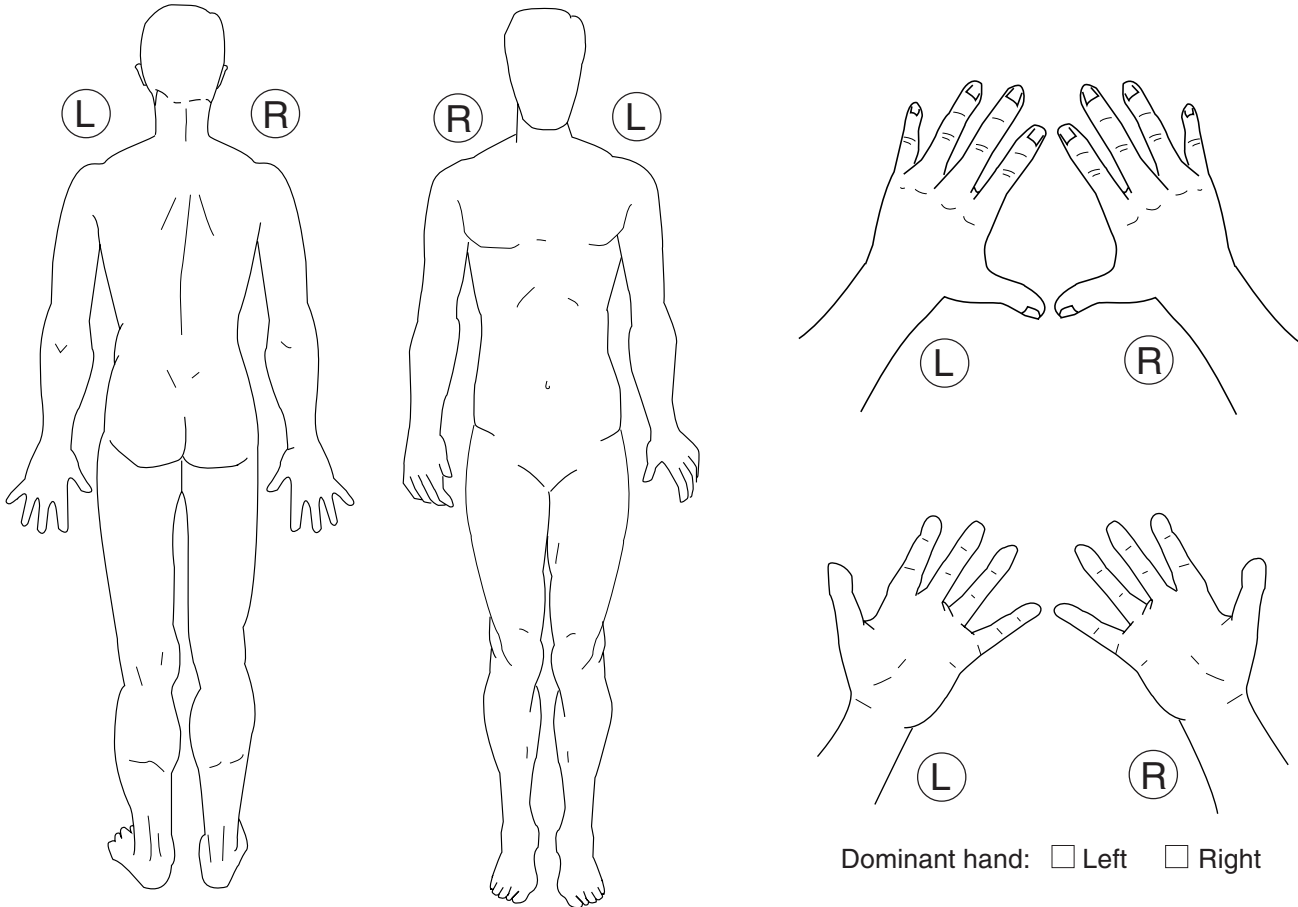
PATIENT'S NAME

DATE

MR#

IMPRINT AREA

REST



DRAW YOUR PAIN

Please draw your diagram with respect to pain at rest (i.e., NOT working, playing sports or doing household activities). Using a pen - mark in the areas on the diagrams where you have pain/numbness.

- X = Pain
- o = Numbness

RATE YOUR PAIN ON THIS SCALE. (Mark with an X)

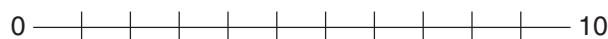
0 = No Pain 10 = Worst possible pain

AS IT APPLIES TO REST PAIN:

LEAST (pain in last 2 weeks)



WORST (pain in last 2 weeks)



Name: _____

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**ACTIVITY
PERMANENT AND STATIONARY REPORT
PAIN DIAGRAM** *Please use a pen*

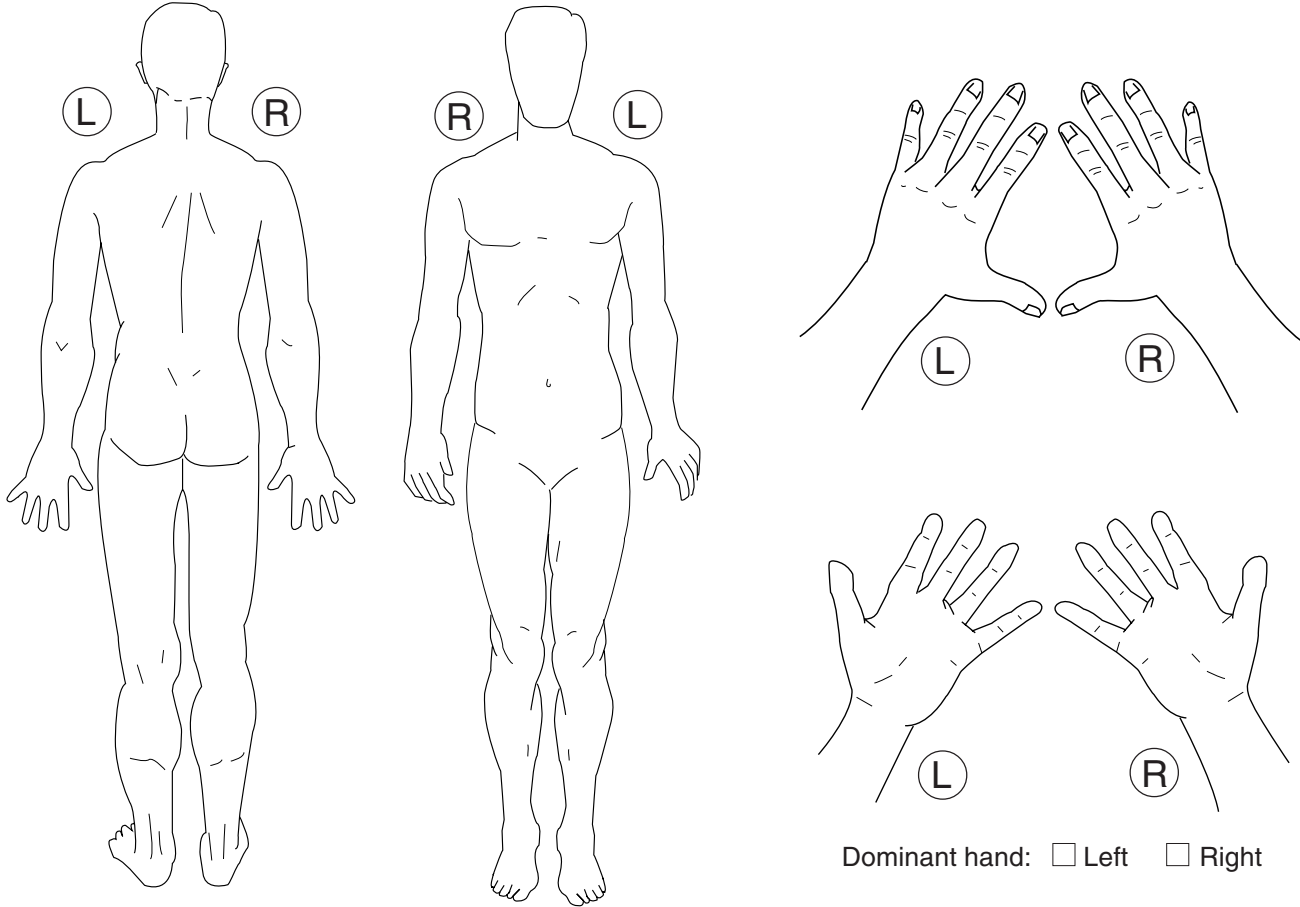
PATIENT'S NAME

DATE

MR#

IMPRINT AREA

WORK / SPORTS / HOUSEHOLD ACTIVITIES



Dominant hand: Left Right

DRAW YOUR PAIN

Please draw your diagram with respect to pain with activity (i.e., work, sports and household activities).
Using a pen - mark in the areas on the diagrams where you have pain/numbness.

- X = Pain
- o = Numbness

RATE YOUR PAIN ON THIS SCALE. (Mark with an X)

0 = No Pain 10 = Worst possible pain

AS IT APPLIES TO PAIN WITH WORK / SPORTS / HOUSEHOLD ACTIVITIES:

LEAST (pain in last 2 weeks)



WORST (pain in last 2 weeks)



