KAISER PERMANENTE®

Patient Label

Consumer # _____

Room# _____

Neurosurgery Spine Center: Patient questionnaire

Patient Name: _____ **Date:** _____

What is your occupation? _____

What questions or concerns would you like to have addressed today? _____

_____

_____

What are your biggest fears about your condition? _____

_____

When did this problem start? _____

Where were you when the problem started? _____

_____

Do you see providers outside of Kaiser Permanente for this condition? ☐ Yes ☐ No

If YES: Name of provider(s): _____

Provider's location: _____

Have you had surgery for this condition? ☐ Yes ☐ No

If YES: What type of surgery? _____

Date (or year) of surgery: _____

Which of the following makes your pain worse (check all that apply):

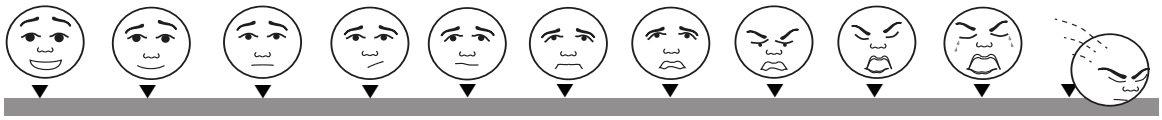
☐ Walking ☐ Bending/twisting ☐ Sitting ☐ Standing ☐ Lying down

Which of the following makes your pain better (check all that apply):

☐ Exercise ☐ Stretching ☐ Lying down ☐ Leaning forward

Pain scale

If you have pain, circle the number that shows how pain affects the activities below.



0	1	2	3	4	5	6	7	8	9	10
No pain	Some pain but OK	Mild pain worse	Annoying pain	Distract-ing pain	Pain can't be ignored for long	Pain can't be ignored at all	It's hard to think and sleep	Pain limits activity; nausea	I cry out in pain	Passed out

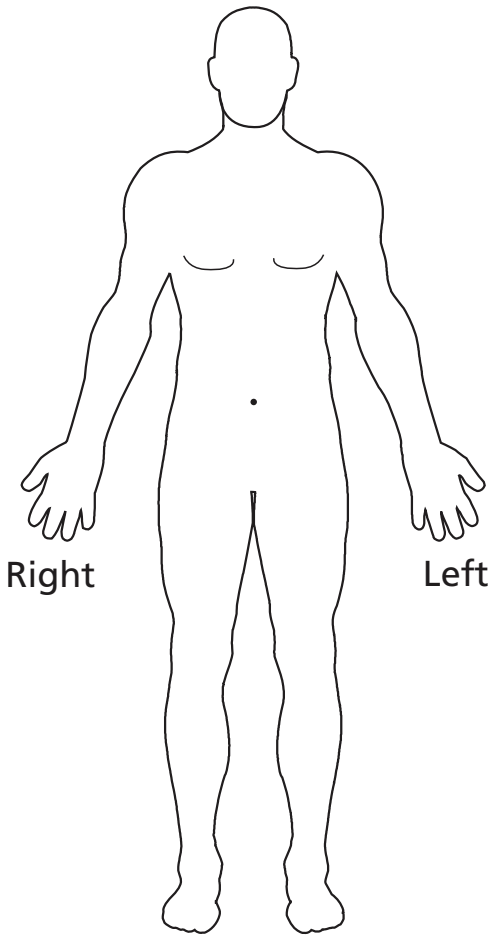
Work:	0	1	2	3	4	5	6	7	8	9	10
Household chores:	0	1	2	3	4	5	6	7	8	9	10
Recreation or exercise:	0	1	2	3	4	5	6	7	8	9	10
Social activities:	0	1	2	3	4	5	6	7	8	9	10
Sex:	0	1	2	3	4	5	6	7	8	9	10
Sleep:	0	1	2	3	4	5	6	7	8	9	10
Eating:	0	1	2	3	4	5	6	7	8	9	10

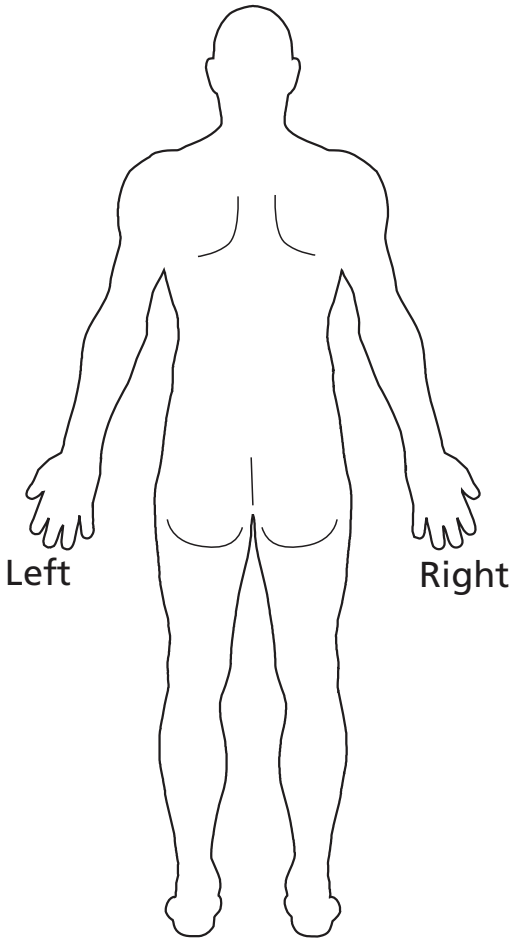
Continued on next page

Pain diagram

On the picture below, use the following marks to show which of these feelings you have on different parts of your body:

Feeling	Mark
Numbness/tingling	- - - - -
Aching	xxxx
Increased sensitivity	ooooo
Sharp pain with motion	/////////





Please check any of the following symptoms you've had in the past 30 days:

- ☐ Fever
- ☐ Night sweats
- ☐ Weight loss
- ☐ Weight gain
- ☐ Depression
- ☐ Anxiety
- ☐ Loss of smell
- ☐ Changes in vision
- ☐ Trouble swallowing
- ☐ Chest pain
- ☐ Hearing loss
- ☐ Shortness of breath
- ☐ Rapid heart rate, heart palpitations
- ☐ Swelling of ankles or legs
- ☐ Stumbling, problems walking
- ☐ Dizziness, feeling lightheaded
- ☐ Nausea or vomiting
- ☐ Pain in the abdomen
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Heartburn, acid reflux
- ☐ Confusion
- ☐ Memory problems
- ☐ Loss of bladder control
- ☐ Frequent urination or thirst
- ☐ Loss of bowel control
- ☐ Join pain, swelling
- ☐ Muscle pain or weakness
- ☐ Numbness or tingling
- ☐ Bruising easily
- ☐ Rash
- ☐ Dry skin