Print

KAISER PERMANENTE®

1. Provider Name _____

2. The **PRIMARY** reason for your visit today:

☐ Abdominal Pain	☐ Ankle Pain	☐ Elbow Pain	☐ Generalized Pain	☐ Headache	☐ Hip Pain
☐ Insomnia	☐ Knee Pain	☐ Lower Back Pain	☐ Mid-Back Pain	☐ Muscle Pain	☐ Neck Pain
☐ Numbness	☐ Shoulder Pain	☐ Stress/Anxiety	☐ Tingling	☐ Wrist Pain	☐ Other
☐ None	☐ TMJ	☐ Sinusitis/Allergies			

3. The **SECONDARY** reason for your visit today:

☐ Abdominal Pain	☐ Ankle Pain	☐ Elbow Pain	☐ Generalized Pain	☐ Headache	☐ Hip Pain
☐ Insomnia	☐ Knee Pain	☐ Lower Back Pain	☐ Mid-Back Pain	☐ Muscle Pain	☐ Neck Pain
☐ Numbness	☐ Shoulder Pain	☐ Stress/Anxiety	☐ Tingling	☐ Wrist Pain	☐ Other
☐ None	☐ TMJ	☐ Sinusitis/Allergies			

4. Have you seen your Primary Care Physician for this condition prior to your CCM? Yes ☐ No ☐

5. Do you plan to see your Primary Care Physician for this condition in the future? Yes ☐ No ☐ Undecided ☐

6. Rate your pain on average.

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No pain — Unbearable pain

7. How much pain do you have right now?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No pain — Unbearable pain

8. What current treatments are you receiving for your condition?

Acupuncture ☐ Massage therapy ☐ Physical therapy ☐ Chiropractic ☐ Other ☐ None ☐

9. What current medications are you receiving for your condition?

None ☐ OTC (over the counter) ☐ Prescription ☐ OTC and Prescription ☐

10. What percentage describes the relief of your condition with your current treatment?

0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100% ☐

No relief — Complete relief

11. Describe how your condition has interfered with your **GENERAL ACTIVITY** in the past 24 hours.

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Does not interfere — Completely interferes

12. Describe how your condition has interfered with your **MOOD** in the past 24 hours.

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
Does not interfere Completely interferes

13. Describe how your condition has interfered with your **WALKING ABILITY** in the past 24 hours.

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
Does not interfere Completely interferes

14. Describe how your condition has interfered with your **NORMAL WORK** in the past 24 hours.

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
Does not interfere Completely interferes

15. Describe how your condition has interfered with your **RELATIONS WITH OTHER PEOPLE** in the past 24 hours.

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
Does not interfere Completely interferes

16. Describe how your condition has interfered with your **SLEEP** in the past 24 hours.

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
Does not interfere Completely interferes

17. Describe how your condition has interfered with your **ENJOYMENT OF LIFE** in the past 24 hours.

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
Does not interfere Completely interferes

18. How did you hear about the Centers for Complementary Medicine? (Please check one option below)

☐Twitter ☐Posted flyer ☐Direct Mailing or Email
☐Customer Service/Call Center ☐Friend/family member ☐KP Partners in Health
☐KP Employee ☐KP Event- Which One? _____
☐Employee promotion/NewsBreak ☐KP Department- Which One? _____
☐Chair massage at KP facility ☐Other (please specify) _____
☐Benefits Packet

Email Address: _____

19. Is this your first visit to a Kaiser Permanente medical office building as a patient? ☐Yes ☐No

Patient Demographics Sticker Here

OFFICE USE ONLY:

Amount Received $ _____

LW SH WM MT

Gift Cert. Coupon Punch Card Benefit