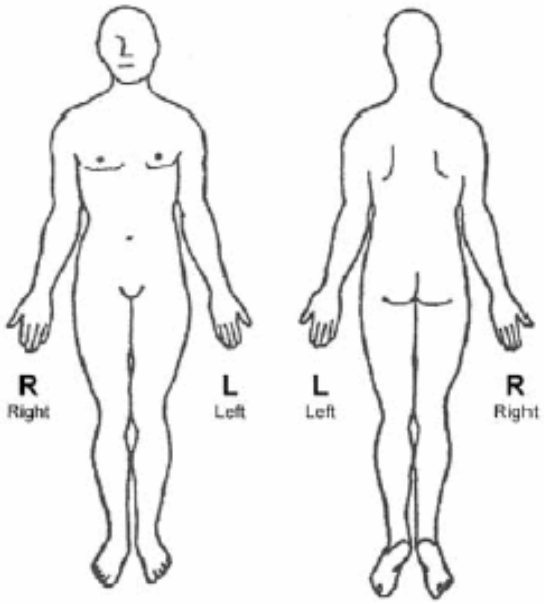
KAISER PERMANENTE®

Sports Medicine
Confidential Patient History Questionnaire

Name	Medical Record Number			Sex ☐ Male ☐ Female
Year in school/Employer	Age	Height	Weight	Dominant Hand ☐ L ☐ R
Sport/Athletic Activity	School/Team/Occupation			
Approximate date injury occurred/pain began?				
Describe how injury occurred/pain began				

Pain Diagram

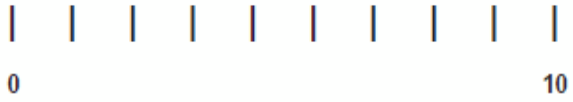
Rate your pain today (mark with XXs)



Pain Scale

Rate your pain on this scale

0 = No pain, 10 = Worst pain possible



Past Medical History

Describe any chronic/current medical conditions
Have you ever had this/similar injury before? If so, when?
Have you ever had surgery before? If so, please describe type and when.
Which treatments have you already tried? ☐ Heat ☐ Physical Therapy ☐ Chiropractor ☐ Medications ☐ Ice ☐ Athletic Trainer ☐ Other _____
List current medications and supplements
Is there anything else we should know that could help us take care of you?
What do you hope to accomplish with this consultation?

To the best of my knowledge, all of the above is true

Signature	Date
Signature of Parent/Guardian if under 18 years old	Date