RICHARD KIM MEDICINE

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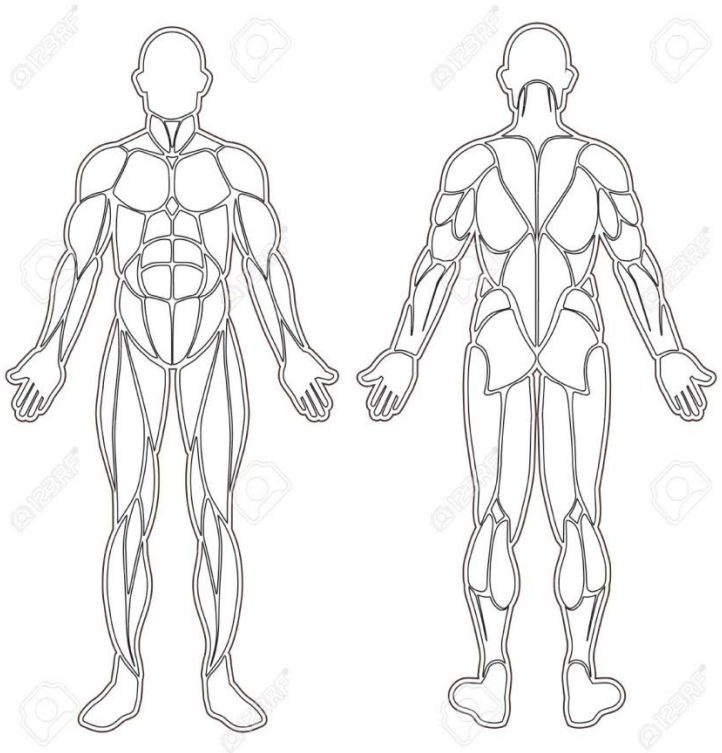
Patient Name:_____

Date of Birth:_____

PATIENT MEDICAL QUESTIONNAIRE
(Please answer all questions to help us best serve you)

Primary reason for appointment(list single problem here)_____



Please "x" on the diagram(s) above where your problem/ pain is located.
How long have you had the problem:_____
Please rate your pain on scale from 0-10(0 being no pain-10 severe pain)?_____
Describe pain in detail_____
Do you have any of the following:
__Yes__ No Numbness/Tingling __Yes __No Bowel/Bladder Function
__Yes__ No Unilateral Weakness __Yes__ No - Therapy trialed for 6 weeks or more.
__ Yes__ No- Exercise trialed for 6 weeks or more.
Is there any exacerbating factors that bring on the pain?_____
Is there anything that relieves the pain?_____
Is there any additional information you would like to add:_____
_____