Vitality Holistic Medicine

PAIN QUESTIONNAIRE

Are you in pain (y/n)? _____ Mark the intensity with a slash on the line below:

_____

1 5 10
(hardly noticeable) (can't stand it)

Please check the blanks that correspond to the type of pain you're experiencing:

_____ sore/achy ____ stabbing ____ throbbing ____ sharp ____ dull ____ burning

____ pins/needles ____ comes and goes ____ shooting/radiating ____ only at night

____ cramping ____ bearing down sensation ____ constant

What makes the pain feel better? _____

_____

What makes the pain worse? _____

_____

How long have you had the pain and do you know what may have triggered it?

_____

_____

How has the pain affected your life (can't sleep, work, exercise, etc.)? _____

_____

What other treatments have you tried for it? _____

TURN PAGE OVER

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Please circle the location(s) of your pain on the drawings below and use an arrow to indicate where it radiates, if applicable: