PAIN DIAGRAM

NAME: _____ DATE: ____/____/____

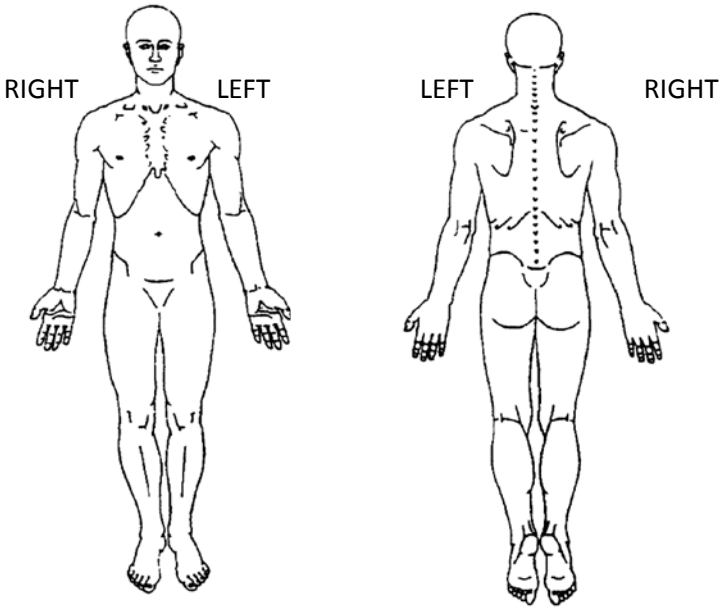
PLEASE COMPLETE THE FOLLOWING "**PAIN DIAGRAM**" BY USING LETTERS AT THE LEFT TO INDICATE YOUR AREAS OF PAIN ON THE DIAGRAM:

PATIENT'S SIGNATURE: _____

ROS:

Intolerance to heat/cold, excessive sweating, or thirst? Yes/No
Night Pains, fevers, unintentional weight change? Yes/No
Vision change, double vision? Yes/No
Chest Pain, palpitations? Yes/No
Shortness of breath, wheezing, coughing after exercise? Yes/No
Nausea, vomiting, black stools, loss of control of stools? Yes/No
New rashes or psoriasis? Yes/No
Dizziness, weakness, numbness, tingling? Yes/No
Depressed mood, sleep problems, anxiety? Yes/No
Current low back pain, joint swelling or muscle pain? Yes/No
Are you pregnant, trying to conceive or breastfeeding? Yes/No
Last menstrual period date: _____Periods regular? Yes/No

Patient Initials: _____



What is your current complaint? (why are you seeking treatment?) _____

_____

How severe is this problem?	**How Frequently?**	**On a 1-10 scale, how would you rate your pain? (10=most painful, 1=least painful)**	**Improvement (%)**
□ Mild			
□Mild to Moderate	□ Constant	□ 1 □ 5 □ 9	□ 10% □ 60%
□Moderate	□ Occasional	□2 □ 6 □ 10	□ 20% □ 70%
□Moderately Severe	□ Intermittent	□3 □ 7	□ 30% □ 80%
□Severe	□ Frequent	□4 □ 8	□ 40% □ 90%
			□ 50% □ 100%

When was the onset of this problem?

□ gradual □ about a day ago □ several months ago
□ sudden □ several days ago □ about a year ago
□ insidious □ about a week ago □ several years ago
□ several weeks ago
□ about a month ago

Select each choice that applies to you

Movement
□ Cramps
□ Inflexibility
□ Restricted Movement
□ Spasm

Sensation
□ Crawling □ Prickly
□ Dead □ Tingling
□ Numb
□ Pins & Needle

What are you doing for exercise now?_____
Number of alcoholic beverages per week? _____
Number of caffeinated beverages per day? _____
Living Situation _____ Typical Breakfast _____
How many meals daily? _____

Select the type of pain that best describes your complaint

□ Achy □ Numb ache □ Shooting
□ Burning □ Pounding □ Stabbing
□ Dull □ Pulsating □ Stinging
□ Excruciating □ Sharp □ Throbbing

Please indicate everything that makes you feel better

□ Usually better in the morning □ Usually better during the day □ Usually better at night

_____
_____
_____

Please indicate everything that makes you feel worse or aggravates your condition

□ Usually worse in the morning □ Usually worse during the day □ Usually worse at night

_____
_____
_____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____