

# Chen's Acupuncture & Chinese Medicine Clinic, P.S.

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Patient Name: \_\_\_\_\_

## Pain Evaluation Form

1. Where is the pain located? Does it radiate?

2. What caused the pain? Is there a diagnosis?

3. Description of pain (please underline all those that apply)

Aching, throbbing, gnawing tender, shooting, stabbing, penetrating, burning, exhausting, tiring, numb, nagging, sharp, continuous, miserable, unbearable, tight

4. What kind of treatment(s) have you tried? (please underline all those that apply)

Medications, physical therapy, manipulation, acupuncture, massage, exercise, TENS, special diets, injections/nerve blocks, rehabilitation, operation, herbs/vitamins, chemotherapy,

or

other: \_\_\_\_\_

5. What medications are you currently taking for your pain? (include dosage)

6. Does this problem interfere with your daily functioning? (if yes, please underline which functions)

Work, mood, sleep, social life, appetite, digestion, sports, sex, walking, grooming, enjoyment of life, concentration

or

other: \_\_\_\_\_

7. Please rate below the severity of your pain on a scale of 1 (very slight) to 10 (unbearable)

Worst pain this month: \_\_\_\_\_

Least pain this month: \_\_\_\_\_

Average pain this months: \_\_\_\_\_

Pain right now: \_\_\_\_\_

8. What increase/triggers/aggravates your pain? (please underline all those that apply)

Stress, activity, rest, cold, heat, rainy weather, touch, sugar, noise, alcohol, smoking, walking, sitting, typing

or

other: \_\_\_\_\_

9. What makes it feel better?