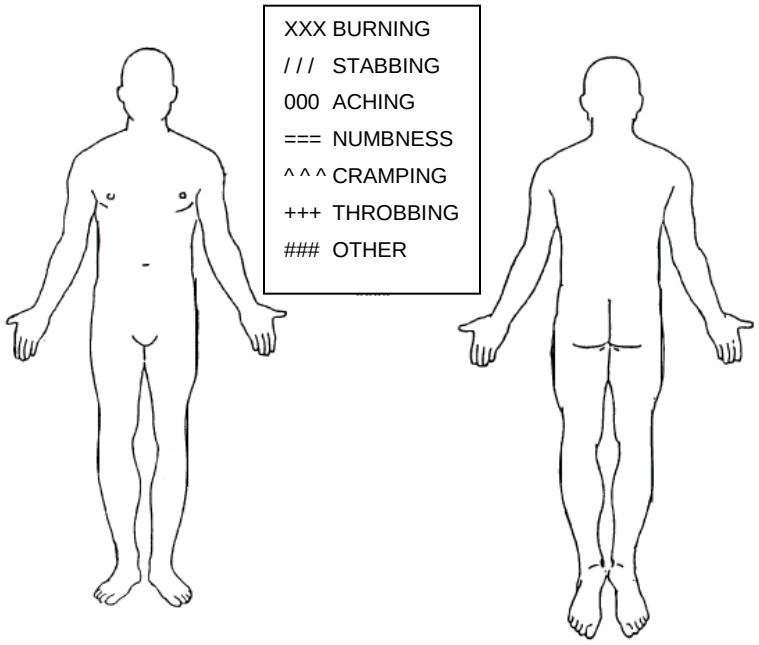
CENTRE FOR NATURAL MEDICINE

NEW PATIENT PAIN QUESTIONNAIRE

PATIENT'S NAME: _____ Age_____ Sex [M] [F]

PLEASE DRAW YOUR PAIN:



When did the pain start? _____

What were you doing when the pain started? _____

Was there any trauma to the area? _____

Where is the pain located? _____

Rate your current pain from 1-10 (10 being the worst)? _____

What time of day does your pain bother you most (am/pm/with activity/with rest etc)?

_____

What makes your pain better? _____

What makes your pain worse? _____

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Have you had any previous episodes of this pain? If yes, when: _____

_____

Have you seen any other practitioners for this pain? If yes, please list: _____

_____

Have you tried any other treatments or medications? If yes please list: _____

_____

Have you had any medical imaging done (X-RAY / MRI / CT)? If yes please list (including date of imaging): _____

_____

Have you had any surgeries? If yes please list (including date of surgery): _____

_____

Do you have any allergies to anesthetics? If yes, which anesthetic and what was your reaction? _____