

Connecticut Center for Natural Health

Pain Questionnaire

Patient Name: _____ Date: _____

PAIN SECTION *(Only complete this portion if pain is one of your chief complaints)*

List condition(s) in order of importance:	Date you first noticed:	Scale your pain - "0" is none & "10" is severe, circle the number None.....to.....Severe	Circle the percentage that represents how much of the time you feel pain or your symptom(s) for the listed reason?
1.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
2.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
3.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
4.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%

For each reason or condition listed above, please circle how it happened:

- | | | | | | |
|--------------------------|-----------|----------|-----------------|---------------|--------------|
| 1. *Developed over time. | *Illness. | *Injury. | *Auto accident. | *Other _____. | *Don't know. |
| 2. *Developed over time. | *Illness | *Injury. | *Auto accident. | *Other _____. | *Don't know. |
| 3. *Developed over time. | *Illness | *Injury | *Auto accident. | *Other _____. | *Don't know. |
| 4. *Developed over time. | *Illness | *injury. | *Auto accident. | *Other _____. | *Don't know. |

For each reason or pain condition, please check if it is better or worse with any of the following:

HEAT	COLD	REST	ACTIVITY	OTHER (describe on line below)
better worse	better worse	better worse	better worse	better worse

- | | | | | |
|----------|-------|-------|-------|-------|
| 1. _____ | _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ | _____ |

Check the box that best describes whether your pain or symptom(s) limit normal activities:

ACTIVITY	NORMAL	SOMEWHAT LIMITED	SEVERELY LIMITED
Lifting			
Bending			
Standing			
Walking			
Sitting			
Climbing stairs			
Running			
Resting in bed			
Intercourse			
Computer work/typing			
Normal work			
Household activities			
Recreational activities			

Other (list below)

Have you had Acupuncture previously? Yes or No What previous treatment have you received for this condition?
