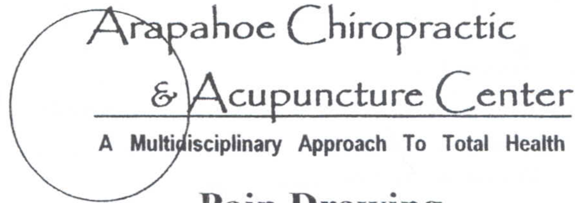


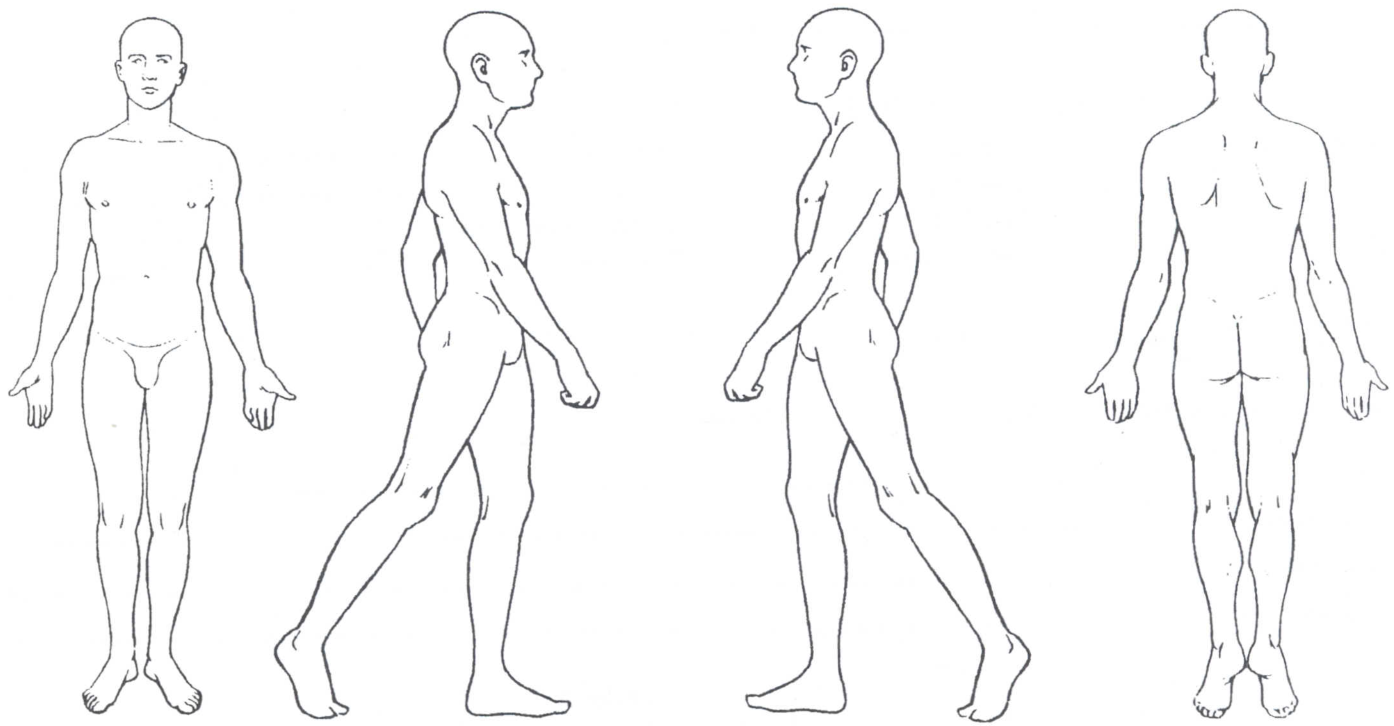
Pain Drawing

Name: ______________________ Date: ____________ D.O.B.: __________

Tell Us Where You Hurt

Please Read Carefully:
Mark the areas on the body diagrams below where you are feeling pain **today**. Include all affected areas. Mark areas of referred pain. *If your pain radiates, please draw an arrow from where it starts to where it ends.* Please extend the arrow as far as the pain travels. Use the appropriate symbol to show the type of pain.

ACHE: >>>> >>>>	**SHARP / STABBING:** xxxx xxxx	**PINS & NEEDLES:** oooo oooo
BURNING: ++++ ++++	**THROBBING:** //// ////	**NUMBNESS:** ~ ~ ~ ~ ~ ~ ~ ~



For each area of pain above, please describe your level of pain on a **1 – 10** scale, **10** being worst pain imaginable, and 5 being a pain that can distract your concentration. Indicate your areas with a number.

Area 1: ___/ 10 **Area 2: ___/ 10** **Area 3: ___/ 10** **Area 4: ___/ 10** **Area 5:___/ 10**

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Health History

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ No Treatment

☐ Other Treatment ______________________________

Name and address of other doctor(s) who have treated you for your condition ______________________________

Date of Last: Physical Exam ______________ Spinal X-Ray ______________ Blood Test ______________

Spinal Exam ______________ Urine Test ______________ MRI, CT-Scan, Bone Scan ______________

Indicate if you have had any of the following: (Check all appropriate boxes)

☐ AIDS/HIV	☐ Chemical Dependency	☐ Herpes	☐ Polio
☐ Alcoholism	☐ Chicken Pox	☐ High Cholesterol	☐ Prostate Problem
☐ Allergies	☐ Diabetes	☐ Kidney Disease	☐ Prosthesis
☐ Anemia	☐ Emphysema	☐ Liver Disease	☐ Psychological Care
☐ Anorexia	☐ Epilepsy	☐ Migraine Headaches	☐ Rheumatoid Arthritis
☐ Arthritis	☐ Glaucoma	☐ Mononucleosis	☐ Rheumatic Fever
☐ Asthma	☐ Goiter	☐ Multiple Sclerosis	☐ Stroke
☐ Bleeding Disorders	☐ Gout	☐ Osteoporosis	☐ Suicide Attempt
☐ Breast Lump	☐ Heart Disease	☐ Pacemaker	☐ Thyroid Problems
☐ Bronchitis	☐ Hepatitis	☐ Parkinson's Disease	☐ Tuberculosis
☐ Bulimia	☐ Hernia	☐ Pinched Nerve	☐ Tumors, Growths
☐ Cancer	☐ Herniated Disk	☐ Pneumonia	☐ Ulcers

☐ Other ______________________________

Exercise	Work Activity	Habits		
☐ None	☐ Sitting	☐ Smoking	*Packs per Day*	________
☐ Moderate	☐ Standing	☐ Alcohol	*Drinks per Week*	________
☐ Daily	☐ Light Laor	☐ Coffee/Caffeine Drinks	*Cups per Day*	________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	*Reason*	________

☐ Pregnant? *Due Date* ______________

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones/Dislocations		
Surgeries		

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Medications	Allergies	Vitamins, Herbs, Minerals
Pharmacy Name ________		
Pharmacy Phone ________		