MEADE DISTRICT HOSPITAL
ARTESIAN VALLEY HEALTH SYSTEM

PAIN DRAWING

PLEASE READ INSTRUCTIONS CAREFULLY

NAME: ______________________________ PHONE:_________________________ DATE:_________________

PLEASE BE SURE TO FILL THIS OUT EXTREMELY ACCURATE. MARK THE AREA ON YOUR BODY WEHERE YOU FEEL THE DESCRIBED SENSATION(S). **USING THE APPROPRIATE SYMBOLS,** MARK THE AREAS OF PAIN, INCLUDE ALL AFFECTED AREAS, **AS YOU FEEL RIGHT NOW.** YOU MAY DRAW IN THE FACE AS WELL.

RIGHT LEFT LEFT RIGHT

KEY

Numbness

Pins & Needles
OOOOOOOOOOOOOOOOOO

Burning
XXXXXXXXXXXXXXX

Stabbing Pain
/ / / / / / / /

Aching Pain
(((((((((

CURRENT COMPLAINT

I have: constant / intermittent / occasional / shooting / burning / aching / sharp / dull

Pain in my: left / right (area of body)

Pain scale: (circle one) 1 2 3 4 5 6 7 8 9 10 (*1 being no pain, 10 being emergency room visit)

Frequency & Duration of pain: ____

I also have:

Numbness in my _________________________________

Tingling in my _________________________

Weakness in my _________________________________

Headaches occurring __________________________

These specific activities **INCREASE** my pain: ____

These specific activities **DECREASE** my pain: ____

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Medical History

*Has this problem affected your daily life or routine? Briefly describe in what ways.*_________________

____

____

Have you had past similar episodes of this current problem? If yes, were you treated with (circle disciplines which apply); Physical Therapy, Acupuncture, M.D. (Meds, TPI's) Massage Therapist, Chiropractor, Pilates, General Exercise, Exercise with Trainer, Self Medicated (Advil), Ignored It, Other. Did they help to alleviate your symptoms? ____

____

Have you undergone any special tests for this condition? (X-rays, MRI's, ETC) If yes, do you know the results? ____

____

Please answer the following questions:

	Yes	No
1) Do the current problems interrupt your sleep?		
2) Do your symptoms change with coughing or sneezing?		
3) Have you had any recent changes in bowel or bladder function?		
4) Do you experience any dizziness or vertigo?		
5) Have you had any recent change in your weight or appetite?		
6) Do you have any intolerance to hot or cold?		
7) Do you have any bruising or bleeding disorders?		
8) Have you had any skin changes, such as rashes or discoloration?		
9) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?		
10) Have you had a recent episode of nausea/vomiting?		
11) Are you pregnant?		
12) Do you have osteoporosis? Date of your last bone scan:		
13) Do you have any allergies?		
14) Have you noticed any shortness of breath or decrease in exercise tolerance?		
15) Do you use any assistive devise? (cane foot orthotics)		
16) Do you have high blood pressure?		
17) Do you have any cardiac problems?		
18) Do you have diabetes?		
19) Have you ever had cancer of any sort?		
20) Do you have a history of neck or back problems?		

*Any other illness, past injuries I should be aware of?*____
*Past surgeries*___*yes,* ___*no, give brief details:* ____
*List the medications you are currently taking (over the counter/prescription):*_______________________

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