ENCINITAS Prolotherapy

PAIN QUESTIONNAIRE

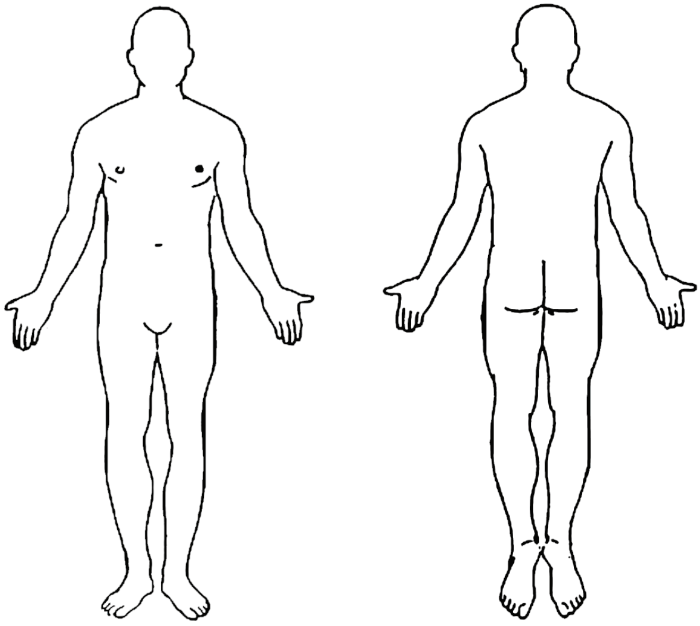
PATIENT INFORMATION

PATIENT NAME:_____ DATE _____

AGE:_____ SEX: M / F

PLEASE DRAW YOUR PAIN

XXX	BURNING
/ / /	STABBING
000	ACHING
===	NUMBNESS
^^^	CRAMPING
+++	THROBBING
###	OTHER



DESCRIBE YOUR PAIN

ON MOST DAYS:	NO PAIN	1	2	3	4	5	6	7	8	9	10	WORST PAIN EVER
AT ITS WORST:	NO PAIN	1	2	3	4	5	6	7	8	9	10	WORST PAIN EVER
AT ITS BEST:	NO PAIN	1	2	3	4	5	6	7	8	9	10	WORST PAIN EVER
TODAY:	NO PAIN	1	2	3	4	5	6	7	8	9	10	WORST PAIN EVER

HOW MANY HOURS OF THE DAY ARE YOU IN PAIN?_____

HOW MANY DAYS PER WEEK ARE YOU IN PAIN? _____

HOW MANY WEEKS PER YEAR ARE YOU IN PAIN? _____

WHAT PAIN MEDICATIONS HAVE YOU TAKEN TODAY? _____

RETURN PATIENTS - AFTER YOUR LAST TREATMENT

PAIN EXPERIENCED: ☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE LASTING _____ DAYS

PAIN RELIEF: ☐ NONE ☐ MILD ☐ MODERATE ☐ MAJOR ☐ TOTAL