PAIN INTAKE FORM **Name:_____ Date_____**

Birthdate: _____ Age: ____ Marital Status: _____ Female_____ Male_____ Ht: _____ Wt: ____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____ Cell: _____ E-mail Address: _____

Occupation: _____ Work Phone: _____ Company: _____

Emergency Contact (Name & relation): _____ Phone: _____

How were you referred for this appointment?

Have you ever been treated with Traditional Chinese Medicine? If yes explain. No _____Yes _____

_____

Do you have a medical diagnoses? If yes explain. _____

_____

What health concern would you like addressed today? _____

What do you feel is the cause of this health concern? _____

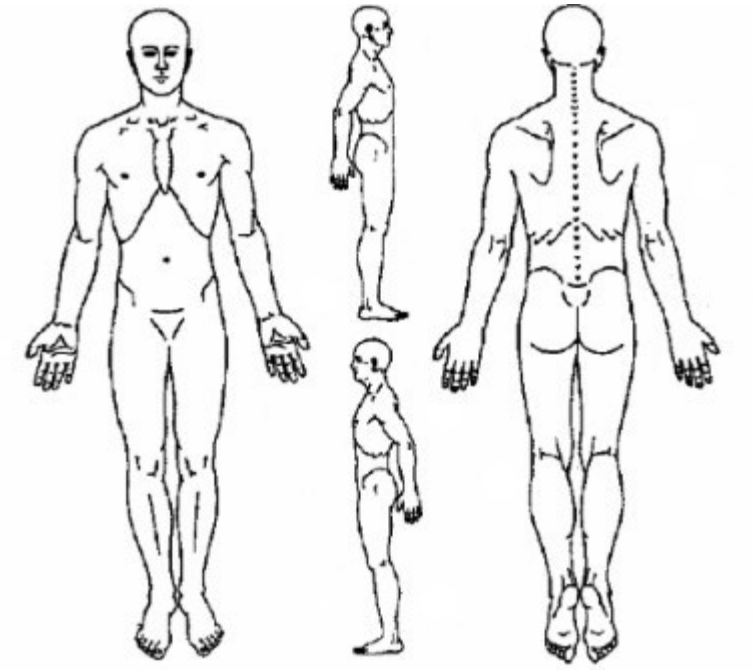
How long have you had this condition? _____

What makes your condition better? _____

What makes it worse? _____

Use diagram to show where you have your

Aching Pain	XXXXXX
Burning Pain	++++++
Numbness	======
Pins and Needles	OOOOOO
Stabbing Pain	/ / / / / /



Check the words which best describe your pain

◊ Sharp
◊ Shooting
◊ Pressure
◊ Dull, aching
◊ Throbbing
◊ Cramping
◊ Burning
◊ Numbness
◊ Muscle pain
◊ Weakness
◊ Pins and needled

What is the severity of your health concern TODAY?

None										Most
0	1	2	3	4	5	6	7	8	9	10