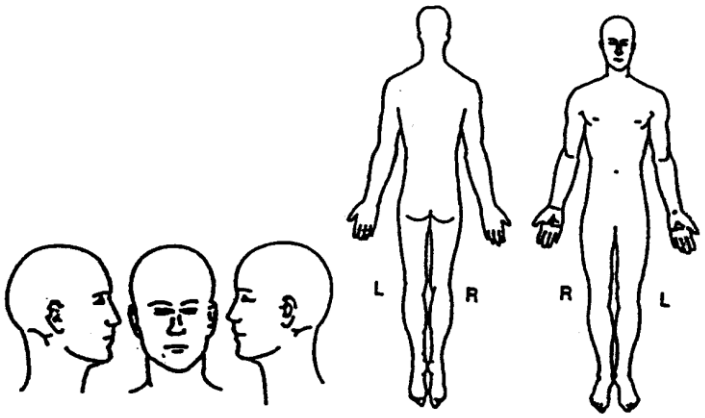
# PAIN DRAWING

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation.

Describe your pain (check all that apply):

- ☐ Constant
- ☐ Intermittent
- ☐ Recurring
- ☐ Stabbing
- ☐ Dull Ache
- ☐ Sharp
- ☐ Deep Ache
- ☐ Throbbing
- ☐ Tingling
- ☐ While Resting
- ☐ Daily
- ☐ During Exercise
- ☐ Nightly
- ☐ _____




Onset of Pain:

- ☐ Sudden
- ☐ Gradual

On a scale of 1 to 10 how would you rate your pain level? _____ ( 1 = Mild, 10 = Intense)

What if anything gives you relief? _____

**Patient Prescription and Vital Information**

Height:_____ Weight:_____ Last Known Blood Pressure Reading:_____/_____

Have you ever smoked? Select Do you still smoke? Select Pack per day_____

**List Allergies**: (Medications, Foods or Products)

**Allergic** **Reaction** **Severity** (Mild, Moderate,Severe)

_____
_____
_____
_____
_____
_____

**List all Prescription Medications: (**or attach a list of medications)

**Name** **Dosage per day** **Milligrams**

_____
_____
_____
_____
_____
_____
_____

**List all over the counter vitamins and medications: (**or attach a list of vitamins/OTC)

_____
_____
_____
_____