**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mark your body pain on the chart using Xs**

****

1. **What treatment have you received for your problem?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Have you had any other previous medical problems (including surgery)?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **List any tablets or medications you are taking regularly now ( including vitamins or supplements)**

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1. **Are you allergic to any drugs or antibiotics, including local anaesthetics?**

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1. **Sleep History:**
* **Difficulty falling asleep: yes ⬜ no ⬜ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Waking up through the night: yes ⬜ no⬜ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **No problems: yes ⬜ no ⬜ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
1. **Energy Levels :**
* **Low ⬜**
* **Medium ⬜**
* **High ⬜**
1. **Do any diseases run in the family?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **How and when does the pain arise?**

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1. **What aggravates your pain?**

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1. **Apart from medication, what relieves the pain?**

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1. **What medications for pain do you take for pain on a bad day?**

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1. **Do you get any other symptoms with your pain e.g. tingling, numbness nausea?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please complete the following questions considering how you have been feeling during the last week?**

1. **Please circle the number that best describes your pain at its worst.**

**0 1 2 3 4 5 6 7 8 9 10**

**No pain ⏵ ⏵ ⏵ worse pain you can imagine**

1. **Please circle the number that best describes your pain at its best.**

**0 1 2 3 4 5 6 7 8 9 10**

**No pain ⏵ ⏵ ⏵ worse pain you can imagine**

1. **Please circle the number that best describes your pain on average.**

**0 1 2 3 4 5 6 7 8 9 10**

**No pain ⏵ ⏵ ⏵ worse pain you can imagine**

1. **Please circle the number that best describes the pain you have right now.**

**0 1 2 3 4 5 6 7 8 9 10**

**No pain ⏵ ⏵ ⏵ worse pain you can imagine**

1. **How much relief have pain treatments and medications provided? Please circle the % that best shows the relief received.**

**0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

**No relief ⏵ ⏵ ⏵ complete relief**

1. **Please circle the number ( 0 no effect, 10 completely interferes with activity) that indicates how the pain has interfered with:**
2. **General activity**

**0 1 2 3 4 5 6 7 8 9 10**

1. **Mood**

**0 1 2 3 4 5 6 7 8 9 10**

1. **Walking ability**

**0 1 2 3 4 5 6 7 8 9 10**

1. **Normal work**

**0 1 2 3 4 5 6 7 8 9 10**

1. **Relations with other people**

**0 1 2 3 4 5 6 7 8 9 10**

1. **Sleep**

**0 1 2 3 4 5 6 7 8 9 10**

1. **Enjoyment of life**

**0 1 2 3 4 5 6 7 8 9 10**

1. **Your usual occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Your hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Have you often been bothered by feeling down, depressed or hopeless?**

**Seldom ⬜ Often ⬜ All the time ⬜**

1. **Do you have little interest or pleasure is your usual activities?**

**Seldom ⬜ Often ⬜ All the time ⬜**

1. **Please list activities that are effected by your condition and circle the number that describes how you are limited your activities are.**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 2 3 4**

**No effect ⏵ ⏵ completely limited**

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 2 3 4**

**No effect ⏵ ⏵ completely limited**

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 2 3 4**

**No effect ⏵ ⏵ completely limited**

**Other information you wish to provide:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thankyou for participating and providing the above information**