KAISER PERMANENTE

Name: _____ MR#: _____ Date: _____

ACUPUNCTURE PAIN ASSESSMENT QUESTIONNAIRE

Please answer the questions as best you can; check all that apply. The information will be used by the Licensed Acupuncturists to help you get the most benefit out of your treatments.

PAIN DESCRIPTION

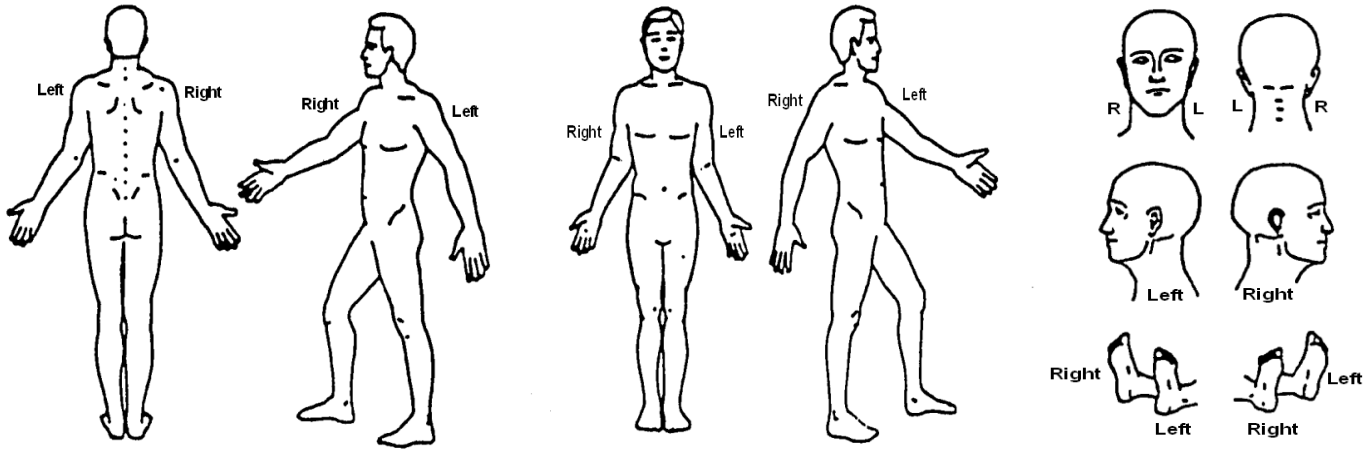
1. Where is your primary pain problem at this time?

◯ Head ◯ Neck ◯ Shoulder ◯ Elbow ◯ Wrist ◯ Hand ◯ Fingers

◯ Low Back ◯ Hip ◯ Knee ◯ Ankle ◯ Foot ◯ Thoracic mid back

◯ Other, specify: _____

Using the figures below, shade the areas where your pain usually occur



2. When did your pain begin? _____ Date of injury: _____

3. Which of the following best describes how the pain began? **Check all that apply**

☐ Accident at home ☐ Work injury ☐ Motor vehicle accident ☐ After surgery

☐ After an illness ☐ Sudden onset ☐ Gradual onset

☐ Other, specify: _____

4. Is the pain? ◯ Constant ◯ Intermittent

5. What type of pain do you have?

☐ Sharp Pain ☐ Dull Pain ☐ Ache ☐ Burning Sensation

☐ Stabbing Pain ☐ Numbness ☐ Tingling ☐ Stiffness

☐ Other, specify: _____

6. Using the following Pain Scale, rate your pain:

◯ 0 = No Pain ◯ 1-3 = Mild ◯ 4-6 = Moderate ◯ 7-9 = Severe ◯ 10 = Hospitalized

Range of pain you have experienced in the last 2 weeks: _____ to _____.

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7. What makes the pain worse?

☐ Cold ☐ Heat ☐ Weather changes ☐ Sitting ☐ Standing
☐ Lying Down ☐ Driving ☐ Walking ☐ Computer Use
☐ Other, specify: _____

8. What helps you feel better (even temporarily)?

☐ Cold ☐ Heat ☐ Positional changes ☐ Rest ☐ Sitting
☐ Walking ☐ Medication
☐ Other, specify: _____

9. What prescription or over-the-counter medications do you take for pain?

Specify: _____

10. Other health concerns: _____

EXERCISE

1. Are you currently exercising on a regular basis? Yes ◯ No ◯

If yes, how many times per week? _____ How many minutes per session? _____

SLEEP

1. Do you take medications or supplements to help you sleep? Yes ◯ No ◯

LIFESTYLES AND HABITS

1. Do you smoke tobacco? Yes ◯ No ◯

Amount per day? _____ How long? _____

Are you interested in resources to assist you in quitting? ◯ Yes ◯ No

2. Do you drink alcohol? Yes ◯ No ◯

How often do you drink alcohol beverages?

◯ Never ◯ 1-2 per month ◯ 1-2 per week ◯ 3-4 per week ◯ Daily

3. How many cups of caffeinated beverages do you consume each day?

Cups of coffee: _____ Soft drinks/caffeine: _____ Caffeinated tea: _____

4. How much water do you drink per day? Ounces: _____ Glasses: _____

5. Do you eat vegetables, fruits, whole grains daily? Yes ◯ No ◯

6. How often do you eat sweets, sugar or processed food? _____