DRAGONFLY Medical Massage Therapy

11038 SC 707, Murrells Inlet, SC 29576
Phone / Fax: 843-215-2151
www.dragonflymedicalmassage.com
info@dragonflymedicalmassage.com

Pain Assessment

Patient Name: _____ Date: _____

1. **History of pain/symptoms**

Check all that you are experiencing:

☐ **Neck Pain** Comments: _____
When did it first begin? _____
Experienced this pain before? No: ___ Yes: ___ then when? _____
Underwent Diagnostic Tests? No: ___ Yes: ___ then specify _____
Underwent Surgery? No: ___ Yes: ___ then what and when? _____
Treated with Injections? No: ___ Yes: ___ then did it help? _____
Treated with Physical Therapy? No: ___ Yes: ___ then did it help? No: ___ Yes: ___ what kind? _____
What makes this worse? _____
What makes this better? _____

☐ **Back pain** Comments: _____
Experienced this pain before? No: ___ Yes: ___ then when? _____
Underwent Diagnostic Tests? No: ___ Yes: ___ then specify _____
Underwent Surgery? No: ___ Yes: ___ then what and when? _____
Treated with Injections? No: ___ Yes: ___ then did it help? _____
Treated with Physical Therapy? No: ___ Yes: ___ then did it help? No: ___ Yes: ___ what kind? _____
What makes this worse? _____
What makes this better? _____

☐ **Arm pain** Comments: _____
When did it first begin? _____
Experienced this pain before? No: ___ Yes: ___ then when? _____
Underwent Diagnostic Tests? No: ___ Yes: ___ then specify _____
Underwent Surgery? No: ___ Yes: ___ then what and when? _____
Treated with Injections? No: ___ Yes: ___ then did it help? _____
Treated with Physical Therapy? No: ___ Yes: ___ then did it help? No: ___ Yes: ___ what kind? _____
What makes this worse? _____
What makes this better? _____

☐ **Leg pain** Comments: _____
When did it first begin? _____
Experienced this pain before? No: ___ Yes: ___ then when? _____
Underwent Diagnostic Tests? No: ___ Yes: ___ then specify _____
Underwent Surgery? No: ___ Yes: ___ then what and when? _____
Treated with Injections? No: ___ Yes: ___ then did it help? _____
Treated with Physical Therapy? No: ___ Yes: ___ then did it help? No: ___ Yes: ___ what kind? _____
What makes this worse? _____
What makes this better? _____

☐ **Tingling / Numbness in Arm** Comments: _____
When did it first begin? _____
Experienced this pain before? No: ___ Yes: ___ then when? _____
Underwent Diagnostic Tests? No: ___ Yes: ___ then specify _____
Underwent Surgery? No: ___ Yes: ___ then what and when? _____
Treated with Injections? No: ___ Yes: ___ then did it help? _____
Treated with Physical Therapy? No: ___ Yes: ___ then did it help? No: ___ Yes: ___ what kind? _____
What makes this worse? _____
What makes this better? _____

☐ **Tingling / Numbness in Leg** Comments: _____

When did it first begin? _____
Experienced this pain before? No: ___ Yes: ___ then when? _____
Underwent Diagnostic Tests? No: ___ Yes: ___ then specify _____
Underwent Surgery? No: ___ Yes: ___ then what and when? _____
Treated with Injections? No: ___ Yes: ___ then did it help? _____
Treated with Physical Therapy? No: ___ Yes: ___ then did it help? No: ___ Yes: ___ what kind? _____
What makes this worse? _____
What makes this better? _____

☐ **Other** Comments: _____

When did it first begin? _____
Experienced this pain before? No: ___ Yes: ___ then when? _____
Underwent Diagnostic Tests? No: ___ Yes: ___ then specify _____
Underwent Surgery? No: ___ Yes: ___ then what and when? _____
Treated with Injections? No: ___ Yes: ___ then did it help? _____
Treated with Physical Therapy? No: ___ Yes: ___ then did it help? No: ___ Yes: ___ what kind? _____
What makes this worse? _____
What makes this better? _____

2. **Does your pain affect any of the following**

Movement No: ___ Yes: ___ then explain _____
Sleep / Rest No: ___ Yes: ___ then explain _____
Emotions No: ___ Yes: ___ then explain _____
Concentration No: ___ Yes: ___ then explain _____
Relationships No: ___ Yes: ___ then explain _____
Bladder No: ___ Yes: ___ then explain _____
Bowels No: ___ Yes: ___ then explain _____
Activities No: ___ Yes: ___ then explain _____
Other: Explain _____

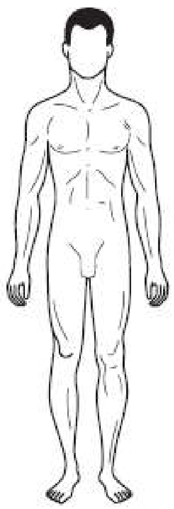
2. **Medications**

Over the Counter medication No: ___ Yes: ___ then explain _____
Prescription Medication No: ___ Yes: ___ then explain _____
Taken today? No: ___ Yes: ___ then explain _____

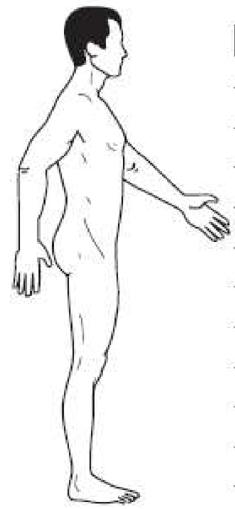
3. **Additional Information that you feel is relative and/or important**

_____
_____
_____

1. **PLACE AN X** at the location of your pain. 2. **CIRCLE THE LEVEL** of pain you experience. 3. **CIRCLE THE TYPE** of pain you are experiencing.



LEVEL	TYPE
10	Aching
9	Burning
8	Constant
7	Dull
6	Numbness
5	Sharp
4	Shooting
3	Stabbing
2	Tender
1	Throbbing
0	Tingling



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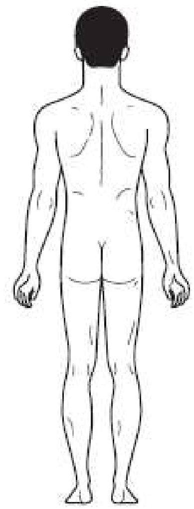

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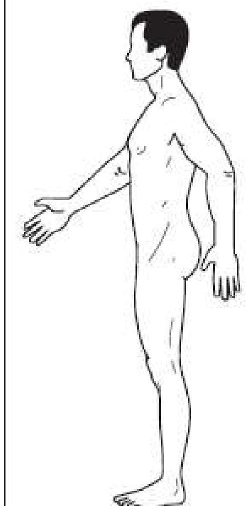

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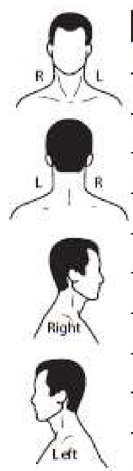

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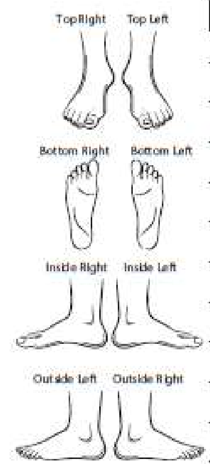

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