Client Information and Pain Questionnaire Form

Personal Information

Date	
Name	
Date of Birth	
Age	

Street Address	
(Unit or Apt. #)	
City	
State	
Zip Code	

Primary Phone	
Alternate Phone	
E-mail	

Pain Questionnaire

What brings you here today? _____

_____

Please describe your typical daily physical activities (occupational or otherwise):

_____

_____

_____

Client Information and Pain Questionnaire Form

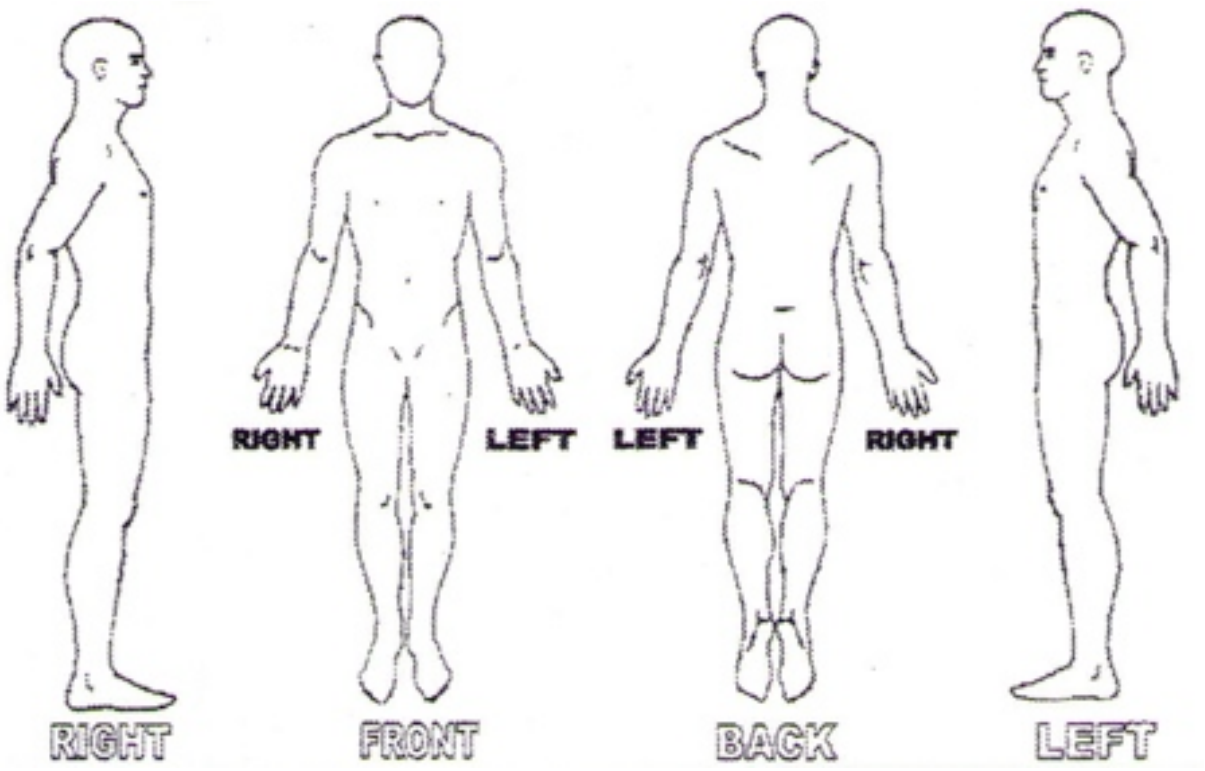
Please describe your current pain complaint: _____

_____

_____

_____

Please indicate (by shading in) where you are experiencing your pain (or other symptoms):



Please indicate (by circling) which term(s) best describe your symptoms:

Aching	Burning	Stabbing	Tender to Touch
Sharp, well defined	Tingling	Shooting	Radiating
Diffuse, poorly defined	Numbness	Cramping	Throbbing

Please indicate (circle) the severity of your pain:

(No Pain) 0-----1------2------3------4------5------6------7------8------9------10 (Severe Pain)

Please describe the event that you think caused your pain (if any):_____

_____

_____

_____

What movements or activities make your pain worse? _____

_____

_____

What can you do to ease your pain? _____

_____

_____

How long have you had this pain? _____

_____

Please indicate if you have been diagnosed with any of the following conditions (check all that apply).

☐ Diabetes (Type I)	☐ Diabetes (Type II)	☐ Heart Disease
☐ Herniated Disc	☐ Spinal Fracture(s)	☐ Migraines
☐ Stroke	☐ Hip Fracture	☐ Hip Replacement
☐ Carpal Tunnel Syndrome	☐ Frozen Shoulder	☐ Plantar Fascitis
☐ Rheumatoid Arthritis	☐ Multiple Sclerosis	☐ Ulcer
☐ Rotator Cuff Tear	☐ TMJ Dysfunction	☐ Cancer

☐ Other:_____

_____

Please identify any surgeries that you have undergone and when:

_____

_____

_____

_____

_____

Is there any other information that you would like to share with the therapist?

_____

_____

_____

_____

How did you find out us ? (circle all that apply)

Referral **Newsletter** **Newspaper Ad** **Search Engine**

Website **TV Ad** **Radio Ad** **Other**

If "referred", who referred you ?_____

If "other", please explain ? _____

_____

Have you ever had massage therapy before ? **Yes** **No**

Have you ever had trigger point therapy before ? **Yes** **No**