

Patient's History Sheet

1. Name: _____ Date of Appointment: _____

2. Age: _____ Sex: _____ Religion: _____ Occupation: _____

3. Address: _____

4. Phone: _____ E-Mail: _____@_____

5. Marital Status: Single / Married / Separated / Other : _____

6. Do you practice Meditation / Yoga/ Asana / Pranayam etc.? : _____

7. Duration of Pain (Days / Months / Years of Suffering from Pain) : _____

8. How would you assess your pain now, at this moment? (Circle your pain score below)

0 1 2 3 4 5 6 7 8 9 10
NoneMild...Moderate..... .. Severe.. Excruciating Max (You may imagine)

9. How strong was the strongest pain during the past 4 weeks?

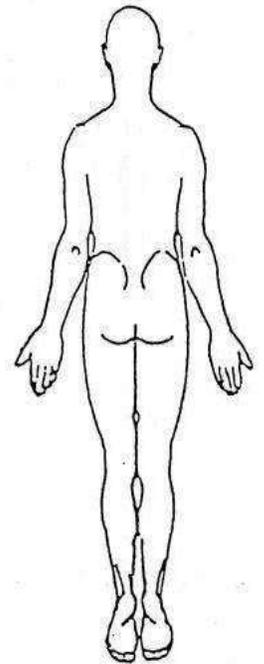
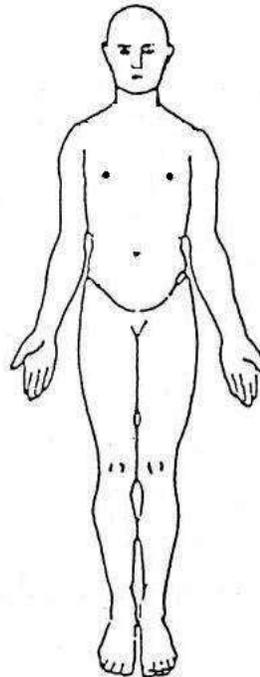
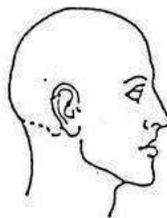
0 1 2 3 4 5 6 7 8 9 10
NoneMild...Moderate..... .. Severe.. Excruciating Max (You may imagine)

10. How strong was the pain during the past 4 weeks on average?

0 1 2 3 4 5 6 7 8 9 10
NoneMild...Moderate..... .. Severe.. Excruciating Max (You may imagine)

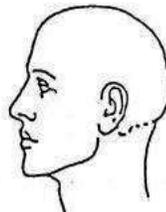
11. Describes the course of your pain: (put cross mark 'X' in the appropriate box)

<input type="checkbox"/>	1.Persistent pain without any fluctuations	<input type="checkbox"/>	2.Pain attacks without any pain in between
<input type="checkbox"/>	3.Persistent pain with sudden severe pain attacks	<input type="checkbox"/>	4.Moderate pain attack with mild pain in between



12. Does your pain radiate/ spread from one part to other parts of your body?

-----YES -----NO



13. Mark the area of Pain in your body on the picture on right hand side:

14. Answer the following questions by putting cross marks (X) in the appropriate boxes:

	Never	Hardly Noticed	Slightly	Moderately	Strongly	Very Strongly
1. Do you suffer from a burning sensation in the marked areas?						
2. Do you have a tingling or pricking of needles sensation or sensation like crawling of ants?						
3. Is light touching (like touch of clothes, blanket) in this area painful?						
4. Do you have sudden pain attacks in the area of your pain like electric shocks?						
5. Is application of cold or heat in this area is painful?						
6. Do you suffer from a sensation of numbness in the areas that you marked?						
7. Does slight pressure in this area, (e.g. with a finger) trigger or aggravate your pain?						

15. Associated complains with pain : _____
(Like: fever, vomiting, headache etc.)

16. When does your pain get worse? _____
(Time of the day: like morning/evening.)

17. Describe your sleep pattern: (Cross 'X' below which is appropriate)
Wake Up Refreshed / Wake Up Fatigued / Toss And Turn Frequently / Can't Find A Comfortable Position.

18. What things increase your pain? (Cross 'X' below which is appropriate)
(Like: lying / bending forward/ sitting / change of posture like sitting to standing / walking / lifting something etc.)

19. What are the medicines that you have taken to reduce pain? _____

20. How much relief are you getting from these medicines? (Cross 'X' below which is appropriate)
Not at all/ partial/ good /excellent

21. Are you suffering from any other diseases? _____
(Like: Diabetes, Hypertension, Hypothyroidism etc.)

22. Did you have any injuries? If yes, please describe it. Start with date of injury:

23. Did you have any operations earlier? If yes, please describe it. Start with name & date/s of operations:

24. Mental Status: (Put cross 'X' mark below in the boxes which is appropriate/ Mark only once for each question.)

	Not at all	Several days, but less than half of a month	Several days, more than half of a month	Nearly every day
A. Little interest or pleasure in doing things				
B. Feeling down, depressed, or hopeless				
C. Trouble falling or staying asleep, or sleeping too much				
D. Feeling tired or having little energy				
E. Poor appetite or overeating				
F. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down				
G. Trouble concentrating on things, such as reading the newspaper or watching television				
H. Moving or speaking so slowly or so restlessly that other people could have noticed.				
I. Thoughts that you would be better off dead, or thoughts of hurting yourself in some way.				

Call us if you have any doubts/questions in filling this form on 033-65361629 (11AM - 5PM). If it is still not clear you may keep that part blank. **But you must bring at least partially filled form before you visit us for consultation.** [HOW TO FILL THIS FORM? CLICK HERE](#)