Sun Acupuncture
Acupuncture • Herbs • Shiatsu-Tuina Massage

Pain and Injury History

What is your primary pain or injury concern:______________________________

What was the cause or nature of the pain or injury?______________________________

How long have you had the pain or injury?______________________________

What treatments have you used?
- ❑ Surgery ❑ Chiropractic Care ❑ Physical Therapy ❑ Other Professional Care:______________
- ❑ Lifestyle Modifications ❑ Pain Medications ❑ Other:______________

How would you describe the pain?
- ❑ Dull ❑ Achiness ❑ Tightness ❑ Stabbing ❑ Burning ❑ Nerve ❑ Pulling

Rate the severity of your pain or injury by checking one box on the following scale: (0 = no pain. 10 = excruciating pain)

0	1	2	3	4	5	6	7	8	9	10

When do you experience the pain?
- ❑ Sporadic/Inconsistent ❑ Constant ❑ Morning ❑ Evening ❑ Other:_______________

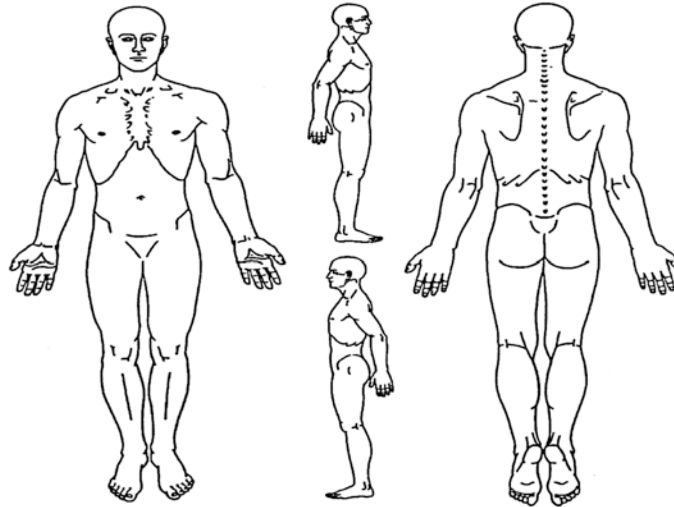
Does it affect any of the following?
- ❑ Working ❑ Sleeping ❑ Sitting ❑ Standing ❑ Driving ❑ Lifting
- ❑ Walking ❑ Exercise ❑ Social Life ❑ Other:_______________

What makes it better?
- ❑ Heat ❑ Cold ❑ Rest ❑ Work/Activity/Overuse ❑ Morning ❑ Evening

What makes it Worse?
- ❑ Heat ❑ Cold ❑ Rest ❑ Work/Activity/Overuse ❑ Morning ❑ Evening

Do you experience any of the following along with the pain or injury?
- ❑ Weakness ❑ Numbness ❑ Tingling ❑ Prickling ❑ Spasms ❑ Burning ❑ Itching

Please locate your pain or injury on the diagram:



Please list any secondary pain or injury concerns:

- ____
- ____

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