

Arapahoe Chiropractic  
& Acupuncture Center  
A Multidisciplinary Approach To Total Health

## Pain Drawing

Name: \_\_\_\_\_ Date: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

### Tell Us Where You Hurt

**Please Read Carefully:**

Mark the areas on the body diagrams below where you are feeling pain **today**. Include all affected areas. Mark areas of referred pain. *If your pain radiates, please draw an arrow from where it starts to where it ends.* Please extend the arrow as far as the pain travels. Use the appropriate symbol to show the type of pain.

ACHE: >>>>  
>>>>

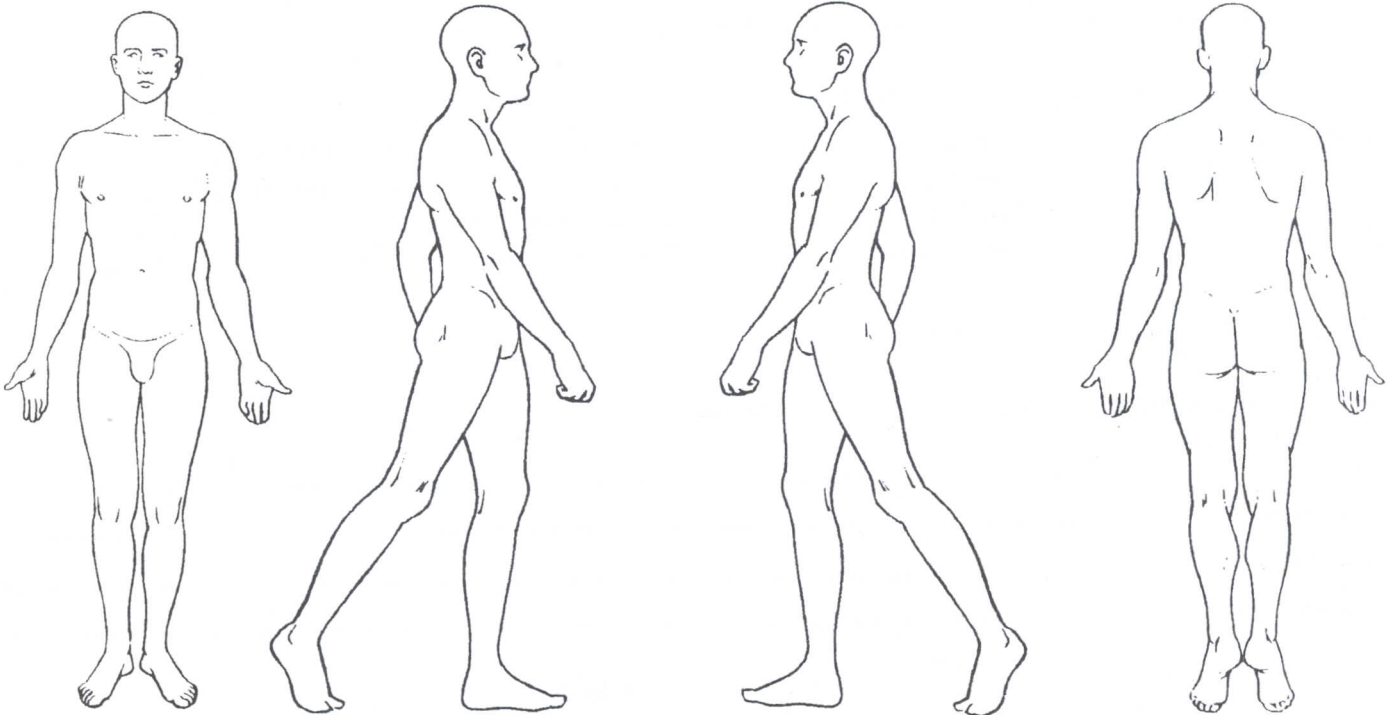
SHARP / STABBING: xxxx  
xxxx

PINS & NEEDLES: oooo  
oooo

BURNING: ++++  
++++

THROBBING: ////  
////

NUMBNESS: ~ ~ ~ ~  
~ ~ ~ ~



For each area of pain above, please describe your level of pain on a 1 – 10 scale, 10 being worst pain imaginable, and 5 being a pain that can distract your concentration. Indicate your areas with a number.

Area 1: \_\_\_ / 10      Area 2: \_\_\_ / 10      Area 3: \_\_\_ / 10      Area 4: \_\_\_ / 10      Area 5: \_\_\_ / 10

What treatment have you already received for your condition?

- Medications                       Surgery                       Physical Therapy                       Chiropractic Services                       No Treatment
- Other Treatment \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
 Spinal Exam \_\_\_\_\_ Urine Test \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Indicate if you have had any of the following: (Check all appropriate boxes)

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Polio                |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Prostate Problem     |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Prosthesis           |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Psychological Care   |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout                | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Suicide Attempt      |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Pinched Nerve       | <input type="checkbox"/> Tumors, Growths      |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Herniated Disk      | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Ulcers               |

Other \_\_\_\_\_

Exercise

- None
- Moderate
- Daily
- Heavy

Work Activity

- Sitting
- Standing
- Light Labor
- Heavy Labor

Habits

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs per Day \_\_\_\_\_  
 Drinks per Week \_\_\_\_\_  
 Cups per Day \_\_\_\_\_  
 Reason \_\_\_\_\_

Pregnant? Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones/Dislocations	_____	_____
Surgeries	_____	_____

Medications

Allergies

Vitamins, Herbs, Minerals

Pharmacy Name _____	_____	_____
Pharmacy Phone _____	_____	_____