

NAME _____

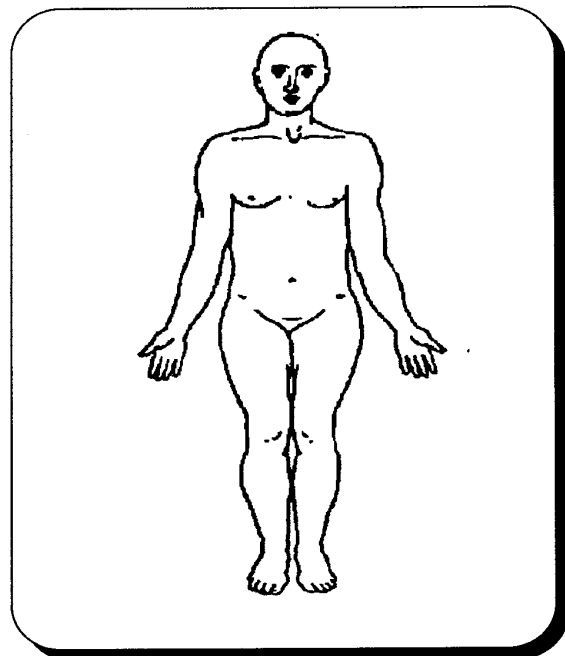
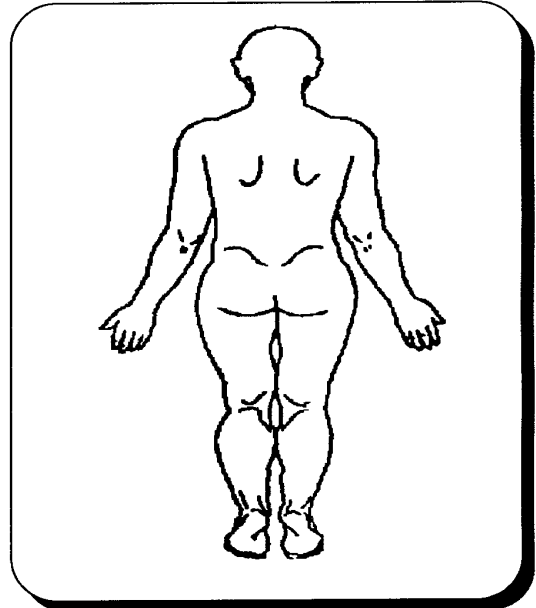
DATE _____

Please tick any of the words that describes your pain under the column that describes it's intensity.

PLEASE DRAW YOUR PAIN

	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				

xxx	Burning	==	Numbness
!!	Stabbing	**	Cramping
00	Aching	##	Other



Your Pain is:

On Most Days	No Pain Discomforting Horrible	Mild Distressing Excruciating
At It's Worst.....	No Pain Discomforting Horrible	Mild Distressing Excruciating
At It's Best.	No Pain Discomforting Horrible	Mild Distressing Excruciating
TODAY	No Pain Discomforting Horrible	Mild Distressing Excruciating

How many hours of the day are you in pain?.....
 How many days per week are you in pain?.....
 How many weeks per year are you in pain?.....
What Drugs Have You Taken Today?.....

Your Pain Today - Tick along scale below .

No Pain [_____] **Worst Possible Pain**

These are some questions that will us understand your condition. Please try to answer them as best as you can. Feel free to add to it. Please circle the best options.

Section A:

- Can you now or could you ever place your hands flat on the floor without bending your knees?
 - Can you now or could you ever bend your thumb to touch your forearm?
 - As a child did you amuse your friends by contorting your body into strange shapes or could you do the splits?
 - As a child or teenager, did your kneecap or shoulder dislocate on more than one occasion?
 - Do you consider yourself double jointed?
 - Did you have significant growing pains?
 - Are you very klutzy (bump into furniture, trip over stairs, bump into doorways)
 - Do you drop things often?
 - Do you bruise easily with minor injuries?
 - Do you have unexplained bruises?
 - Do you have stretch marks since young age?
-

Section B:

- Do you have skin flushing?
- Do you have itchiness?
- Do you have skin flushing after a warm shower?
- Do you sweat a lot (e.g. wake up sweating)?

- Brain fog?
- Allergies:
- Difficulty maintaining weight (weight gain or weight loss despite trying your best)?
- Acid reflux?
- Nausea?
- Do you get diarrhea and constipation intermittently?
- Hair - Is your hair dry / brittle or have hair loss (circle the ones that apply)?
- Nails – do they have ridges, white spots, short dark white lines?
- Eyes – do you have dry eyes, grittiness?
- Do your eyelids tremble?
- Ears: do you get ear infections, hearing loss, ringing in your ears or have hearing loss?
- Nose and sinus: Do you get frequent sinus infections, nose bleeds, hearing loss?
- Mouth – do you get burning in your mouth?