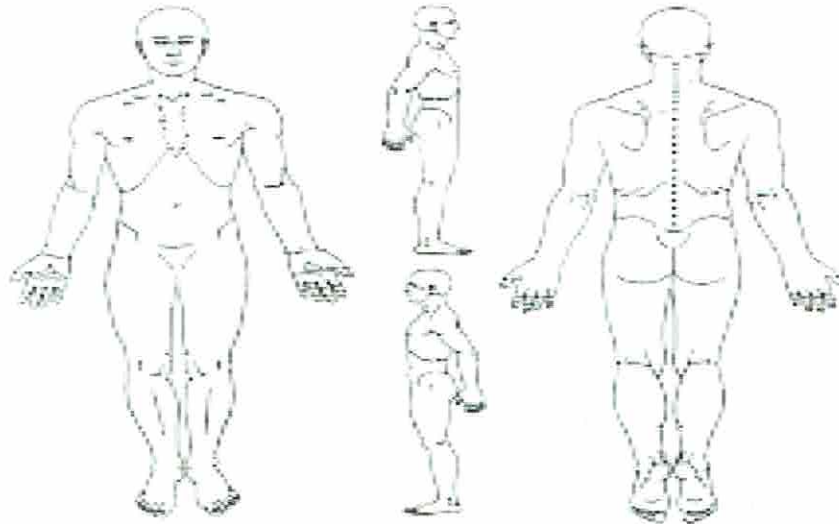


Pain

Please answer the following questions if you have pain.
Please indicate on the diagram specific areas of pain:



Quality of pain: Dull Sharp Stabbing Sore Cramping
 Burning Constant Fixed Moving

What decreases the pain? Ice Heat Rest Movement Pressure
 Moisture Massage Nothing Other: _____

What aggravates the pain? Ice Heat Rest Movement Pressure
 Moisture Massage Nothing Other: _____

On a scale of 1-10 (10 being extreme) how strong is your pain today? _____ On average? _____

Does the pain radiate? Y N Where? _____

List other treatments you have had for your pain?

Causes of Pain: Injury Accident Disease Unknown
 Other: _____

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Acu Health And Beauty Acupuncture Clinic 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

Signed: _____

Date: _____

Parent/Guardian (Print and Sign): _____

Date: _____