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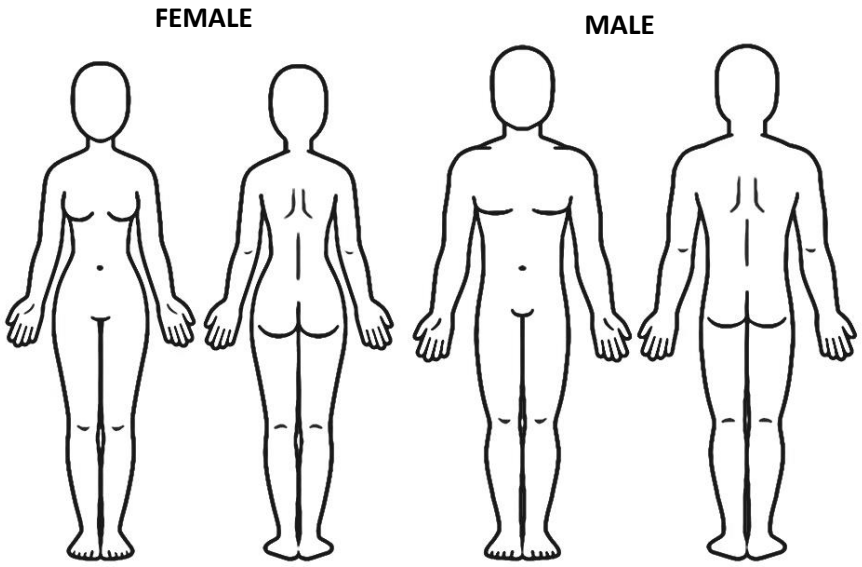
PROLOZONE THERAPY PAIN QUESTIONNAIRE

DATE: _____

PATIENT'S NAME: _____ **DOB: _____**

PLEASE DRAW YOUR PAIN ON THE FOLLOWING OUTLINE:

XXX BURNING
/// STABBING
000 ACHING
==NUMBNESS
^^^CRAMPING
++THROBBING
OTHER



YOUR PAIN IS (CIRCLE ONE):

On most days: NO PAIN—1—2—3—4—5—6—7—8—9—10 WORST PAIN IMAGINABLE

At its worst: NO PAIN—1—2—3—4—5—6—7—8—9—10 WORST PAIN IMAGINABLE

At its best: NO PAIN—1—2—3—4—5—6—7—8—9—10 WORST PAIN IMAGINABLE

Today: NO PAIN—1—2—3—4—5—6—7—8—9—10 WORST PAIN IMAGINABLE

How many hours of the day are you in pain? _____

How many days per week are you in pain? _____

What pain medications have you tried in the past?

_____

FOR RETURN PATIENTS ONLY:

Since my last treatment (circle one):

I experienced (NO), (MILD), (MODERATE), (SEVERE) flare- up which lasted _____ days.

I experienced (NO), (MILD), (MODERATE), (MAJOR), (TOTAL) relief from my pain.