

Power Over Pain Pain Survey

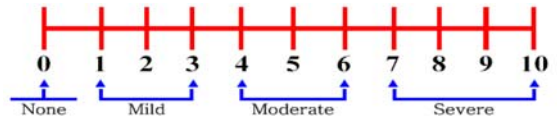
Do you have pain? Yes No

Male Female

What is your age? under 20 years
 20 – 30
 30 – 40
 40 – 50
 50 – 60
 60 – 70
 70 – 80
 80 – 90
 > 90

Where is your pain? Back
 Neck
 Joints
 Head
 Stomach
 Muscles
 Chest
 Other _____

Rate your pain on 0 – 10 scale Now
 At its best
 At its worst



What do you do to relieve your pain?
(mark all that apply)

- Prescription Medication
- Over the counter medication
- Herbal medicine
- Rest
- Massage
- Heat/cold application
- Acupuncture
- Other _____

Who do you see to help you with your pain? (mark all that apply)

- Pain Specialist
- Family Physician
- Nurse Practitioner
- Massage Therapist
- Chiropractor
- Alternative Medicine _____
- Other _____
- I do not seek any care for my pain