



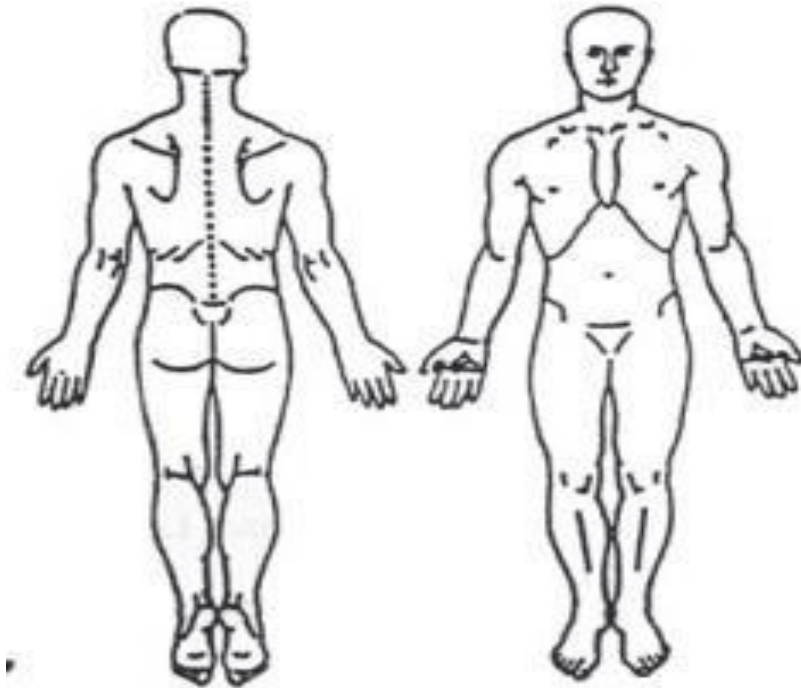
# DHARMA ACUPUNCTURE & YOGA

## Areas of Pain

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please indicate the location of pain and the symbol that best describes the discomfort you are presently experiencing

Sharp and stabbing	++++
Dull and achy	VVVV
Pins and needles	0000
Numbness	////



MY PAIN IS

- Mild     
  Moderate     
  Severe

Please check the boxes below to describe your present limitations in function

<b>Activity</b>	<b>Normal</b>	<b>Mildly Limited</b>	<b>Moderately Limited</b>	<b>Severely Limited</b>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resting in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>