Dr. Naran
PAIN AND WEIGHT MANAGEMENT CLINIC

Dr. M Naran MD, CAFCI

Family Physician, Trigger Point Therapy, Laser Acupuncture

Personal Information:

LAST NAME: _____ FIRST NAME: _____

BIRTH DATE: (D/M/Y) / / _____ CARE CARD # _____

PHONE _____ EMAIL: _____

ADDRESS: _____

_____

NAME OF FAMILY DOCTOR: _____

HOW DID YOU HEAR ABOUT US?: _____

Pain Questionnaire:

1) Chief complaint or problem area(s) of your pain:

_____

How long have you had this pain?:

_____

#206A-145 West 15th St, North Vancouver, BC, V7M 1R9, Canada Website: **www.doctornaran.com** Email: **info@doctornaran.com** Phone: **(604) 986-4214** Fax: **(604) 980-4208**

2) Please circle a number related to the range of your pain:

0 1 2 3 4 5 6 7 8 9 10

No pain Severe pain

3) Please circle the percentage of the day you experience this pain:

0-25% 26-50% 51 -75% 76 – 100%

4) What other treatments have you tried to manage this pain? (circle):

Physiotherapy Massage Chiropractic Other: _____

5) How far can you walk? (circle):

N/A Unable Indoors only I00 - 500m – I km More than I km

6) How difficult is it to do the following activities? (circle):

	Not Difficult										Difficult
Exercise / Sport:	0	1	2	3	4	5	6	7	8	9	10
Work:	0	1	2	3	4	5	6	7	8	9	10
Sleeping:	0	1	2	3	4	5	6	7	8	9	10
Daily chores / housework:	0	1	2	3	4	5	6	7	8	9	10

7) Please list any BLOOD THINNERS and / or PAINKILLERS you are taking:

_____

8) Do you have any allergies to LOCAL ANESTHETICS?

_____

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