No image

Chronic Pain Clinic Survey Date:26.1.2022.

Please complete the survey below to help us collect the required information before your chronic pain clinc appointment

Thank you!

Patient name: GUTTA CHANDRA Hospital Id: undefined

Patient Details:	
FirstName:GUTTA	
LastName: CHANDRA	
Contact:	undefined
Are you filling this form :	For Others
Address:	gnt
Postcode:	52522
Email:	satishgutta09@gmail.com
Date of Birth:	undefined
Year Pain Began:	undefined
How did Pain Start:	
was the onset of pain:	undefined
Sex:	Female
Please indicate what words describe your pain now	
Any comments you wish to make:	
How often do you have pain?:	
Are there times during which you experience no pain?:	
Time of day pain is best:	
Time of day pain is worst:	
What causes an increase in your pain?:	

What can you do to help relieve the pain?:

What can you do to help relieve the pain?:

Does pain affect your sleep?

Trouble falling asleep

Medication needed to fall asleep

Awakened by pain

Any comments you wish to make:

Please tick if you have seen any of the following people regarding your pain?:

Please give details of any tests or investigations you have had for the pain listing the health professinals and hospitals if possible

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Blood Tests

Nerve Tests

Regular Medication

Medication 1 - Name	sardon
Medication 1 - Dose	50mg
Medication 1 - Frequency	3 times/day
Medication 2 - Name	
Medication 2 - Dose	
Medication2 - Frequency	
Medication 3 - Name	
Medication 3 - Dose	
Medication 3 - Frequency	