If you are experiencing any kind of pain as a result of injury or otherwise, please make an appointment at the NOMC.

Pain management is important for ongoing pain control, especially if you suffer from long-term or chronic pain. Different types of pain require different pain management options. Your doctor can prescribe certain pain treatments or medicine based on your individual needs.

As part of our services at the NOMC, we partner with local providers who offer a range of pain management or rehabilitation services including Physical Therapy, Feldenkrais Method, and Myofascial Release Physical Therapy. Talk to our Nurse Practitioner about the pain you’re experiencing and treatment options available to NOMC patients.

Please contact office@nomaf.org for more information.

Before your appointment, please fill out the PERFORMANCE PAIN SYMPTOM MONITOR to help us better understand how to help you heal.
Performance Overview

Is your right or left leg dominant?  
☐ Right  ☐ Left

What type of dance/parading do you do (primary)? ____________________________
Secondary? ____________________________

What surface do you perform on? ____________________________
Other genres/styles? ____________________________

How old were you when you started dancing/parading? ____________________________
What type of dance/parading? ____________________________

Did you receive professional training? If so, where and when? ____________________________

On average in the past 6 months, how many hours per week do you PRACTICE? ___________ Hours.

On average in the past 6 months, how many hours per week do you PERFORM? ___________ Hours.

Do you warm up before you perform? How? ____________________________

What is your primary occupation? ____________________________

What is your upcoming performance schedule? ____________________________

Do you have performance anxiety?  
Circle One:  
0 1 2 3 4 5 6 7 8 9 10  
no anxiety  high anxiety

Have you heard of noise induced stress?  
☐ Yes  ☐ No

Have you ever had it?  
Circle One:  
0 1 2 3 4 5 6 7 8 9 10  
no noise induced stress  high noise induced stress

Do you have pain when you perform?  
Circle One:  
0 1 2 3 4 5 6 7 8 9 10  
no pain  unbearable pain

How often do you experience pain?  
Circle One:  
almost never  monthly  weekly  daily  almost constantly
Injuries

Have you had any injuries that you believe affect your ability to perform? If so, please describe. (If you need more space, please continue on the back of this page.) 

[Blank space for description]

Were you ever treated for these injuries?  □ Yes  □ No

If yes, by whom?  □ Doctor  □ Chiropractor  □ Physical Therapist  □ Other __________________________

If you haven’t been treated, why not? __________________________

Check all symptoms that apply to your injury below:

□ dull ache  □ difficulty walking  □ fatigue  □ slowed finger  □ weakness  □ inaccurate fingering  
□ throbbing  □ stiffness  □ discomfort  □ tingling  □ sharp shooting  □ sharp non-shooting  
□ numb  □ stinging/burning  □ cramping  □ swelling  □ tenderness  □ redness  
□ other __________________________

Please EITHER mark the diagram below OR fill in the chart on the next page.

On the diagrams to the right, indicate all areas the symptoms below with the corresponding symbol.

• pain : P
• numbness : nbn
• tingling : ttt
**Name:** ___________________  **Date of Birth:** ________________  **Age:** ___________________

**In the past 6 months, please indicate what symptoms you have had. (mark all that apply)**

<table>
<thead>
<tr>
<th>Area of Injury</th>
<th>None</th>
<th>Pain</th>
<th>Weakness</th>
<th>Stiffness</th>
<th>Swelling</th>
<th>Numbness or Tingling</th>
<th>Decreased Coordination</th>
<th>Other Symptoms</th>
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<tbody>
<tr>
<td>Mouth</td>
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<td>Upper Back</td>
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<td>Lower Back</td>
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<tr>
<td>Shoulder/Upper Arm (right)</td>
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<td>Elbow/Forearm (right)</td>
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<td>Elbow/Forearm (left)</td>
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<td>Hip/Buttocks/Thigh</td>
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<td>Knee/Lower Leg</td>
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<td>Ankle/Foot/Toes</td>
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<td>Other (please specify)</td>
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</table>

**In the past 6 months, have you had symptoms associated with dancing/parading?**  
☐ Yes  ☐ No

If YES, it STARTS about ______ minutes/hours after I start to dance/parade.  
it STOPS about ______ minutes/ hours after I stop dancing/parading.  
Other patterns? ________________________________

**In the past 6 months, have you missed practice, rehearsals or performances due to symptoms?**  
☐ Yes, approximately ____ days  ☐ No

**Do you have any other conditions, illnesses and medicines which may be impacting your pain?**

__________________________________________

**PLEASE USE BACK OF THIS PAGE TO PROVIDE US WITH FURTHER INFORMATION TO AID YOUR PROVIDER IN HELPING YOU.**