**PRE-PAIN ESSENTIAL OIL USAGE STUDY QUESTIONNAIRE**

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

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| Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Age (years): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Your Sex (M or F):\_\_\_\_\_\_\_\_\_\_\_ | |  | |  |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |

FILL OUT OTHE FOLLOWING INFORMATION TO THE BEST OF YOUR ABILITY

Have you ever used essential oils to improve the health concern?

Yes No

**Question 1**: How often do you feel joint or muscle pain in the last week?

Very often Often Sometimes Rarely Never

**Question 2**: Evaluate pain intensity on a scale of 0-10. (0 = no pain and 10 = very intense pain)

0 1 2 3 4 5 6 7 8 9 10

**Question 3**: How often do you take prescription or over the counter pain killers?

Rarely once a day Several times a day Several times a week

**Question 4**: How long have you experienced this pain? (weeks/Months/years) \_\_\_\_\_\_\_\_

**Question 5**: How often do you feel pain from tension or discomfort during the week?

Rarely once a day Several times a day Several times a wee

**Question 6**: After using prescription or over the counter pain medication how often do you feel common side effects (eg. Stomach pain, loss of appetite, drowsiness, nausea)?

Very often Often Sometimes Rarely Never

**Question 7**: Does your pain stop you from any normal physical activities?

Yes No

**Question 8**: If you answered yes to question 7, which activities are you no longer able to participate in because of Pain: