

PLEASE PRINT LEGIBLY

Patient Name \_\_\_\_\_

Patient, please complete the following questions regarding how you feel today and in the past week.

**1. How do you feel today?**

**Circle your pain level today.**

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

**In the past week, how often have your symptoms been present?**

Constantly  Frequently  Intermittently  Occasionally  None

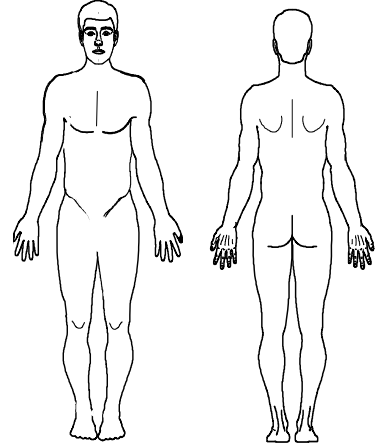
**Circle your average and the worst pain level over the past week.**

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

**Currently, how much has your pain interfered with your daily activities?**

No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



**2. Are you getting better?**

**Current Condition(s)/Complaint(s)**

**Rate your overall progress since starting acupuncture**

|         |                                    |                               |                               |                               |                                |
|---------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|--------------------------------|
| 1 _____ | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Worse |
| 2 _____ | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Worse |
| 3 _____ | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Worse |
| 4 _____ | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Worse |

**3. Which type(s) of treatment have been helpful to your condition(s)?**

Acupuncture treatment       Nutritional supplements       Rehab Exercise/Home Care  
 Chinese herbs       Prescription Medication(s)       Spinal Adjustment/Manipulation  
 Massage therapy       Physical therapy       Other \_\_\_\_\_

**4. Is there anything new?**

Have you had any new complaints/conditions?  No  Yes Explain \_\_\_\_\_

Have you had any re-injuries or events that have prolonged your recovery?  No  Yes

Explain \_\_\_\_\_

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_