Primary Care Physician:_____ Physician Phone #:_____

Employer:_____ Job Description:_____

Are you under the care of a physician? No_____ Yes_____ for what conditions? _____

Please describe your current health problem(s): _____

When it began? _____ How it happened? _____

What treatment have you received for the above condition(s)? Surgery_____ Medications_____ Physical Therapy_____ Chiropractic_____
Massage_____ Injections_____ Other_____

How often are your symptoms in the past week? 0-10%_____ 11-20%_____ 21-30%_____ 31-40%_____ 41-50%_____
51-60%_____ 61-70%_____ 71-80%_____ 81-90%_____ 91-100%_____

Average Pain Level in the past week	0	1	2	3	4	5	6	7	8	9	10	(*10 = Excruciating)
Worse Pain Level in the past week	0	1	2	3	4	5	6	7	8	9	10	(*10 = Excruciating)
Current Pain Level	0	1	2	3	4	5	6	7	8	9	10	(*10 = Excruciating)
How has it interfered with your daily activity: [Currently]	0	1	2	3	4	5	6	7	8	9	10	(*10 = Excruciating)

New Complaints? No_____ Yes_____ Explain: _____

Re-injuries? No_____ Yes_____ Explain: _____

Which type of treatment(s) have been helpful to your condition(s)? Acupuncture_____ Chinese Herbs_____ Massage Therapy_____

Nutritional Supplements_____ Prescription Medication(s)_____ Physical Therapy_____ Rehab/Home Care_____

Spinal Adjustment/Manipulation_____ Other_____

List the activities (sleep, work, recreation) you are monitoring for progress and any measurable results:*

Activity	Measurements (how much, how long, how far?)	How has it changed
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pain Medication (Name, Dosage, Frequency): _____

Pertinent Health history: _____

Pain Quality: Sharp_____ Throbbing_____ Ache_____ Burning_____ Numb_____ Tingling_____

Rate overall progress since starting acupuncture: Excellent_____ Good_____ Fair_____ Poor_____ Worse_____

How long does relief last? Hours_____ if so, how many_____ Days_____ if so, how many_____ ; If varies, indicate from last treatment

Which treatment course would you like for upcoming visits? 1/week _____ 2/week _____ Will you be out of town, if so please indicate when?

Height ____ft ____inches Weight_____lbs Blood Pressure_____/_____

Pregnant? No_____ Yes_____ # of weeks_____ Physician for Pregnancy_____

TODAY'S DATE: SIGNATURE: _____