



Acupuncture Questionnaire

Name: _____ Date: _____

Primary Care Physician: _____

Physician's Phone Number: _____

Are you on any blood thinners (aspirin, plavix, Coumadin, Warfarin, etc.)?: _____

Is there a chance you are pregnant?: _____

1. Start by listing in order of importance (1 being the most important) the reasons you wish to see the doctor.

1.
2.
3.
4.

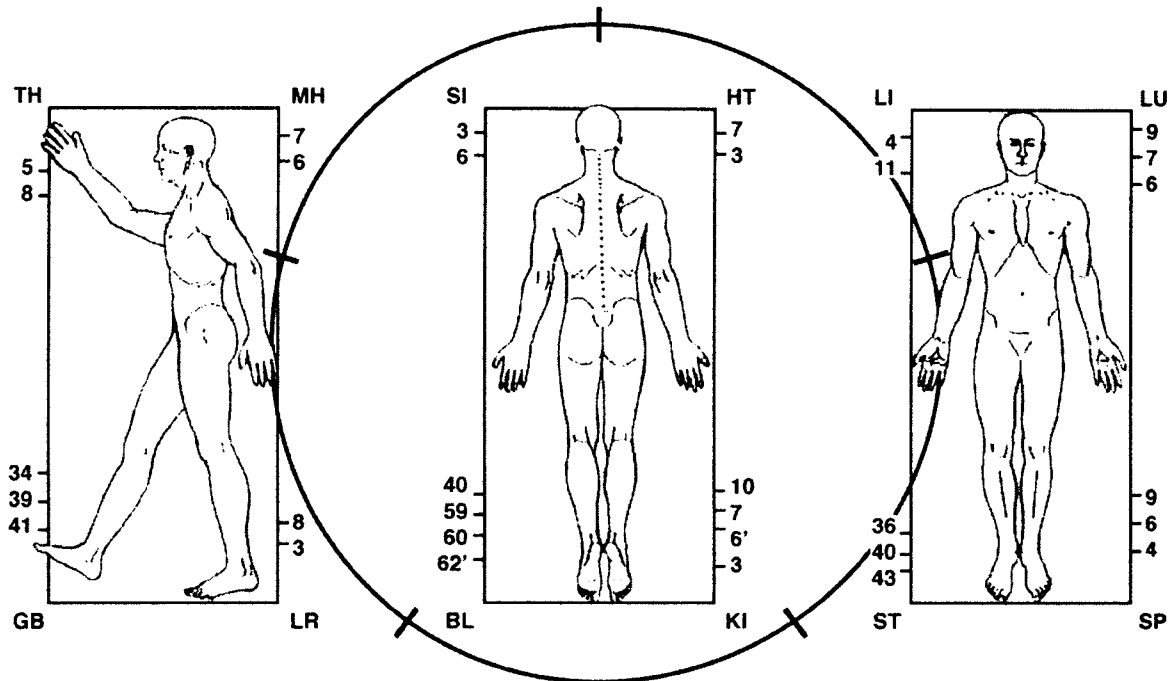
Instructions:

Please circle or check the answers that apply to you at least 80% of the time. Be nonjudgmental and don't think about the answers too much. Leave blank any boxes that do not apply to you or that you are unsure of. There are no correct answers. Your honesty will result in a better treatment.

2. Please circle one answer for each of the following questions.

Five phase questions	Wood	Fire	Water	Earth	Metal
My favorite season	Spring	Summer	Winter	Harvest (late summer)	Autumn
My favorite color	Blue – Green (turquoise)	Red	Dark Blue or Black	Yellow (earth tones)	White
My favorite flavor	Sour, citrus, acidic	Bitter, roasted	Salty	Sweetness	Spicy, flavorful
My predominant emotional tendency	I tend to get angry.	I am excitable.	I get scared.	I tend to worry.	I tend to feel sad
My predominant psychological characteristic	I tend to be anxious and irritable.	I am joyful and creative.	I am willful and ambitious.	I often find myself in deep thought.	I tend to get depressed.
My usual reaction to stress	I clench. My muscles get tight.	I tend to cry.	I tremble. My body feels shaky.	My stomach feels upset.	My chest feels tight.
My fingernails can be characterized as	Elongated	Long and narrow	Crescent moon	Triangular	Rectangular

3. On the anatomical figures below mark the area or areas where you have pain or other problems. Please be as accurate as possible about the locations.



JUE YIN / SHAO YANG

Pain Assessment
Location:
Onset:
Makes Better:
Makes Worse:
Associated Symptoms:
Quality: ☐ constant ☐ intermittent ☐ sharp ☐ dull ☐ pressure ☐ burning
Severity: 1 2 3 4 5 6 7 8 9 10

SHAO YIN / TAI YANG

Pain Assessment
Location:
Onset:
Makes Better:
Makes Worse:
Associated Symptoms:
Quality: ☐ constant ☐ intermittent ☐ sharp ☐ dull ☐ pressure ☐ burning
Severity: 1 2 3 4 5 6 7 8 9 10

TAI YIN / YANG MING

Pain Assessment
Location:
Onset:
Makes Better:
Makes Worse:
Associated Symptoms:
Quality: ☐ constant ☐ intermittent ☐ sharp ☐ dull ☐ pressure ☐ burning
Severity: 1 2 3 4 5 6 7 8 9 10

Treatments I've tried: ☐ Physical therapy ☐ Chiropractic ☐ Injections ☐ _____

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain **presently** prevents you from doing what you would normally do. Regarding each category, please indicate the **overall** impact your present pain has on your life, not just when the pain is at its worst.

Please **circle the number** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL—

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES—

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING OUT AND ATTENDING OTHER SOCIAL FUNCTIONS—

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS—

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

5. **SELF CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED—

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

6. **LIFE SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING—

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

PATIENT NAME: _____

DATE: _____

SCORE _____ [60]

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition **right now**.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____

PRINTED

Total Score _____

Signature _____

Date _____