ACUPUNCTURE FOR CHRONIC LOW BACK PAIN - ELIGIBILITY FOLLOW-UP QUESTIONNAIRE

Your Name: _____
Last, First

Date Of Birth: _____ **Residence:** _____
Day/Month/Year

How often do you feel the pain:

Constantly Many times a day Once a day Once a week Once a Month or Less

When do you feel the pain : (Circle all that apply)

At Rest With activity With certain positions Lying Sitting Standing

What is your pain usually on a scale of 1-10 ten being the most painful?

1 2 3 4 5 6 7 8 9 10

Does the pain impair your activity on a scale of 1-10 ten being the greatest level of impairment?

1 2 3 4 5 6 7 8 9 10

Does the pain impair your mood on a scale of 1-10 ten being the greatest level of impairment?

1 2 3 4 5 6 7 8 9 10

Does the pain impair your quality of life on a scale of 1-10 ten being the greatest level of impairment?

1 2 3 4 5 6 7 8 9 10

Do you feel Acupuncture has helped you with your Lower Back Pain? (1 being not at all 10 being complete relief)

1 2 3 4 5 6 7 8 9 10

Do you feel Acupuncture has helped your mobility or ability to be active? (1 being not at all 10 is absolute improvement)

1 2 3 4 5 6 7 8 9 10

Do you feel Acupuncture has improved your mood? (1 being not at all 10 incredibly improved)

1 2 3 4 5 6 7 8 9 10

Do you feel Acupuncture has improved your Quality of Life? (1 being not at all 10 more than you could have imagined)

1 2 3 4 5 6 7 8 9 10

Do you feel Acupuncture has harmed you in any way? (1: Yes 10. not at all)

1 2 3 4 5 6 7 8 9 10

Do you want to continue receiving Acupuncture for Low Back Pain? Y N

Signature:_____ Date:_____