

ACUPUNCTURE ELIGIBILITY QUESTIONNAIRE - INITIAL

Your Name: _____
Last, First

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

Have you had Low Back Pain for more than 12 Weeks/ 3 months? Y N

How Long have you had Low Back Pain? Estimate: (circle)

>12 weeks >1 year > 5 years. > 10 years

Is your back pain due to Rheumatoid Arthritis, Fracture, Infection, Cancer, or Fibromyalgia
(as these conditions are not eligible to receive acupuncture for low back pain)?
Y N

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 take narcotics to control your pain? (circle one) Y N

If so, how many times a day/week? (circle one)

>3xper day 2x a day 1x a day >3 x a week <3 x a week

Signature: _____

Date: _____