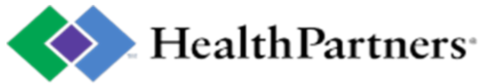


Acupuncture – BRIEF SYMPTOM INVENTORY

To be completed by the patient

Patient Name ______________________________ **HealthPartners ID #** __________________________ **Acupuncture Provider** _______________________	**Current Date** _____________________ **I have received ___ # of acupuncture treatments for <u>this condition</u> this *<u>Treatment Year</u>*.**

1. Condition of symptom(s) for which you will be or have been receiving acupuncture treatment:

2. Please rate your pain or symptom by circling the number that best describes your pain or symptom currently:

A. Main symptom ____

Severity/Intensity	0 No pain	1	2	3	4	5	6	7	8	9	10 Severe
Frequency	0 Never	1	2	3	4	5	6	7	8	9	10 Constant
Duration	0 Never	1	2	3	4	5	6	7	8	9	10 Constant

B. General fatigue: Lack of energy/strength/stamina/endurance; Inability to complete a normal day's obligation/tasks

0 1 2 3 4 5 6 7 8 9 10
No problem Severe

C. Mobility, Agility, Range of motion, Ability to sit/stand / walk

0 1 2 3 4 5 6 7 8 9 10
No problem Severe

D. Sleep Disturbance: Difficulty falling or staying asleep; Waking too early; not rested upon waking in morning

0 1 2 3 4 5 6 7 8 9 10
No problem Severe

E. Decreased quality of life: Negative mood; Poor coping ability or emotional r4esiliency; Significant relationships strained

0 1 2 3 4 5 6 7 8 9 10
No problem Severe

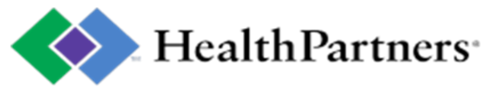
3. If medications have been recommended or prescribed for your condition, please complete the following:

Name of Medication: ____

a. How frequently do you take this medication?
b. Is this more ____ or less ____ frequent than recommended by your physician?
c. How much do you take each time?
d. Is this more ____ or less ____ as is recommended by your physician?

(Use separate sheet if needed for medication list)

4. Additional Significant Comments:


HealthPartners