Seattle Acupuncture Associates

515 Minor Avenue, Suite 16
Seattle, Washington, 98104
206 622-0246
206 624-0766 Fax

PEASE TAKE A MOMENT AND ANSWER THE FOLLOWING QUESTIONS. THIS INFORMATION WILL ASSSIST YOUR PROVIDER IN THE MANAGEMENT OF YOUR CASE.

1. What is the reason you were referred to our clinic? _____

2. What are the primary areas of your complaint?

   Head and neck ___ Upper Back ___
   Shoulders ___ Upper extremities ___
   Low back ___ Hips ___
   Lower extremities ___
   Additional comments _____

3. On the line below please make a hash mark for the lowest and the highest pain you experience.

   Low 0_____10 High

4. Please rate the frequency in which you experience your pain.

   a. Constantly ____
   b. Frequently ____
   c. Intermittently ____
   d. Occasionally ____

5. How long have you experienced your primary reason for your visit today? _____
   _____

6. Does pain interrupt your sleep? _____yes no_____: If yes, How?
   _____

7. Do you take a sleep aid/medication? _____

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8. Do you take prescribed pain medications? _____yes no_____ If yes, what kind with dosage? _____

   _____

9. Have any of your daily activities been limited by your current health? _____

Patient Signature: _____ Date: _____