HealthPartners

Acupuncture – BRIEF SYMPTOM INVENTORY

To be completed by the patient

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

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