

## Acupuncture – BRIEF SYMPTOM INVENTORY

*To be completed by 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> .
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**1. Condition or 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 obligations/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										Severely Limited

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 resiliency; 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 is recommended by your physician?
- c. How much do you take each time? \_\_\_\_\_
- d. Is this more \_\_\_ or less \_\_\_ or the same \_\_\_ as is recommended by your physician?
- e. Is this more \_\_\_ or less \_\_\_ or the same \_\_\_ as you were taking before you started acupuncture?

(use additional sheet if needed for medication list)

**4. Additional Significant Comments:**

\_\_\_\_\_

**USE THIS PAGE ONLY IF YOU HAVE MORE MEDICATIONS TO REPORT**

Please list the medications you have been prescribed for treatment of the main condition:

- Name of medication \_\_\_\_\_
- a. How frequently do you take this medication? \_\_\_\_\_
  - b. Is this more \_\_\_ or less \_\_\_ frequent than is recommended by your physician?
  - c. How much do you take each time? \_\_\_\_\_
  - d. Is this more \_\_\_ or less \_\_\_ or the same \_\_\_ as is recommended by your physician?
  - e. Is this more \_\_\_ or less \_\_\_ or the same \_\_\_ as you were taking before you started acupuncture?

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- a. How frequently do you take this medication? \_\_\_\_\_
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  - e. Is this more \_\_\_ or less \_\_\_ or the same \_\_\_ as you were taking before you started acupuncture?

- Name of medication \_\_\_\_\_
- f. How frequently do you take this medication? \_\_\_\_\_
  - g. Is this more \_\_\_ or less \_\_\_ frequent than is recommended by your physician?
  - h. How much do you take each time? \_\_\_\_\_
  - i. Is this more \_\_\_ or less \_\_\_ or the same \_\_\_ as is recommended by your physician?
  - j. Is this more \_\_\_ or less \_\_\_ or the same \_\_\_ as you were taking before you started acupuncture?