

Acupuncture Survey



Print your name: _____ Your relationship to participant: _____

Participant's name: _____ Participant's Social Security Number: _____

FOR OFFICE USE ONLY	Please fax completed forms to 702-691-5620 .
Reason for visit _____	Date _____ Visit number _____

We need your help to know if your acupuncture treatment is working. Please help us by answering the following survey questions about your pain.

- Please respond to each item by marking one box per row.
- Answers should be about how you have felt over the last week.

How much pain you feel



I had/have no pain

Mild

Moderate

Severe

Very severe

How bad was the worst pain you had?

How bad was your pain each day?

How bad is your pain right now?

How pain affects you

Not at all

A little bit

Somewhat

Quite a bit

Very much

How much did the pain get in the way of doing your job duties?

How much did the pain get in the way of doing work around the home?

How much did the pain get in the way of participating in social activities?