Absolute Balance Acupuncture Clinic

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Please take a few moments to fill out this form.
It will allow us to better treat you during your time in our office. Thanks!

Name: ..... Date .....

Choose one or two symptoms (physical or mental) which bother you the most. Write them on the lines. Now consider how bad each symptom is, over the last week, and score it by circling your chosen number.

SYMPTOM 1: ..... 0 ..... 1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 .....7.....8 .....9 10
As good as it could be — As bad as it could be

SYMPTOM 2: ..... 0 ..... 1..... 2..... 3 ..... 4..... 5..... 6.....7.....8.....9.....10
As good as it could be — As bad as it could be

Now choose one activity (physical, social or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.

ACTIVITY: ..... 0..... 1..... 2..... 3..... 4..... 5..... 6.....7.....8.....9.....10
As good as it could be — As bad as it could be

Lastly how would you rate your general feeling of wellbeing during the last week?

..... 0..... 1..... 2..... 3..... 4..... 5..... 6.....7.....8.....9.....10
As good as it could be — As bad as it could be

How long have you had Symptom 1, either all the time or on and off?

Please circle: 0 - 4 weeks 4 - 12 weeks 3 months - 1 year 1 - 5 years over 5 years

Are you taking any medication FOR THIS PROBLEM? Please circle: YES NO
IF YES:

1. Please write in name of medication, and how much a day/week:.....
.....

2. Is cutting down this medication:

Please circle:.....Not important..... a bit important..... very important.....not applicable

IF NO: Is avoiding medication for this problem:

Please circle:.....Not important .....a bit important .....very important .....not applicable