Patient Pain Survey – Acupuncture Treatment

Patient Name: _____ Date: _____
Phone: _____ DOB: _____

1. Main Concern
Please check all that apply:
☐ Lower Back Pain (LBP)
☐ Shoulder Pain
☐ Neck Pain
☐ Knee Pain
☐ Carpal Tunnel Syndrome
☐ Arthritis
☐ Hip Pain
☐ Sinus Issues
☐ Allergies
☐ Other: _____

2. Pain Location(s)
Mark on the diagram where you feel pain:
[Front & back body outline diagram]

3. Pain Severity *(circle one for each)*
0 = No Pain | 10 = Worst Pain Possible

- Lower Back: 0 1 2 3 4 5 6 7 8 9 10
- Shoulder: 0 1 2 3 4 5 6 7 8 9 10
- Neck: 0 1 2 3 4 5 6 7 8 9 10
- Knee: 0 1 2 3 4 5 6 7 8 9 10
- Wrist/Hand: 0 1 2 3 4 5 6 7 8 9 10
- Other: _____ 0 1 2 3 4 5 6 7 8 9 10

4. Pain Description *(check all that apply)*
☐ Sharp
☐ Dull/Aching
☐ Burning
☐ Tingling/Numbness
☐ Throbbing
☐ Stiffness
☐ Other: _____

5. Pain Frequency
☐ Constant
☐ Comes and goes
☐ Worse in the morning
☐ Worse at night
☐ Other: _____

6. How long have you had this pain?
☐ Less than 1 month
☐ 1–3 months
☐ 3–6 months
☐ Over 6 months

7. What makes the pain better?
☐ Rest
☐ Heat
☐ Cold
☐ Movement/Exercise
☐ Massage
☐ Other: _____

8. What makes the pain worse?
☐ Movement
☐ Rest
☐ Cold weather
☐ Stress
☐ Other: _____

9. Previous Treatments
☐ None
☐ Acupuncture
☐ Physical Therapy
☐ Chiropractic Care
☐ Medication
☐ Surgery
☐ Other: _____

10. Goals for Acupuncture Treatment
☐ Reduce pain
☐ Increase mobility
☐ Improve sleep
☐ Reduce stress
☐ Other: _____