Great Wall Chinese Medicine and Acupuncture

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For GWCM Use Only
Appointment Time: _____ Check-in Time: _____
Treatment Room #: ___ Last Visit Date: _____
Acupuncture/Therapy Name: _____
Modalities (check all that apply):
☐Acupuncture ☐Moxibustion ☐Cupping ☐Herbs

Patient Self-Assessment

(Answer the following questions according to your average condition for the past several days or since last treatment.)

Patient's Name: (Last) (First) (MI)

Patient Follow-Up Questionnaire (For pain management only, skip to Pain Details section)

Reasons/Issues for Today's Visit (besides pain): 1. 2.

Overall Response to Treatment Do you feel the treatment helped your overall well-being? ☐ Yes ☐ No
If yes, how long did the benefit last? ____ days____ hours

Daily Function Morning Refreshed: ☐ Yes ☐ No Energy Level (1-10): ____ Brain foggy: ☐ Yes ☐ No
Mental focus : ____ hours/day Afternoon Tiredness Level (1-10): ____ Stress Level (1-10): ____
Social Engagement: ☐ Yes ☐ No, Level (1-10): _____ Mood: ☐ Optimistic ☐ Calm ☐Agitated ☐ Anxious ☐ Depressed
Exercise: ☐ Cardio ☐ Strength/Flexibility ☐ Meditation, ☐ Indoor ☐ Outdoor: ____ hours/week

Sleep Easy to fall asleep? ☐ Yes ☐ No Sleep from _____ to _____ total: ____ hours/night
Wake-ups: _____ times/night, due to: ☐ Urination ☐ Pain ☐ Dreams ☐ Sweating ☐ Hot flash
Time to fall back asleep: ____ minutes Sleep Quality Level (1-10): ____

Appetite & Digestion Easily hungry? ☐ Yes ☐ No Loss of appetite? ☐ Yes ☐ No Sleepy after meals? ☐ Yes ☐ No
Food Cravings: ☐ Salty ☐ Sweet ☐ Carbs ☐ Oily ☐ None Craving Intensity Level (1-10): ____

Bowel Movements Frequency: ____ times/day or runs ____ /week Ease: ☐ Easy to go ☐ Hard to push out
Stool Shape: ☐ Normal ☐ Solid ☐ Loose ☐ Dry stool ☐ Diarrhea ☐ Constipation

Urination Characteristics: ☐ Dark color ☐ Frequent ☐ Leaky ☐ Foamy ☐ Normal

Other Symptoms Ringing in ears: ☐ Yes ☐ No Dizziness: ☐ Yes ☐ No Bloating: ☐ Yes ☐ No
Gassy: ☐ Yes ☐ No Acid Reflux: ☐ Yes ☐ No Mouth taste: ☐ Bitter ☐ Sticky ☐ Normal
Dryness Symptoms: ☐ Mouth ☐ Throat ☐ Lips ☐ Eyes ☐ Skin ☐ Hair ☐ Nails ☐ Vagina ☐ None

Pain Details (Continue if you have pain)

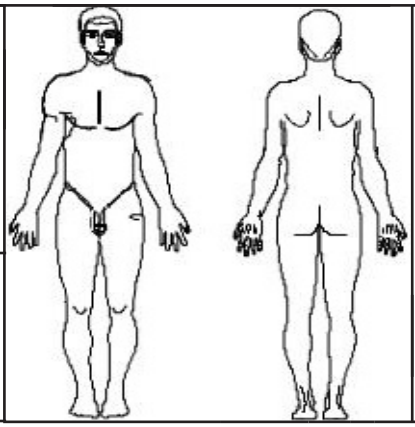
Overall, do you feel treatment is helping your symptoms? ☐ Yes ☐ No
Did the last treatment help you better perform daily activities?
☐ Yes ☐ No, ☐ Difficulty sitting ☐ Standing long ☐ Walking long distances ☐ Driving
If symptoms returned, it was: ☐ Gradual ☐ Sudden
Time and cause of increased pain (check all that apply): ☐ Morning ☐ Night ☐ Weather ☐ Lack of sleep ☐ Mood swings
Do you feel like you are progressing towards your treatment goals? ☐ Yes ☐ No

Primary Area of Pain: _____

Second Area of Pain: _____

1) Pain Level (1-mild to 10-Unbearable): Now _____
Lowest pain level since last treatment: _____ Highest: _____
2) Frequency of pain: ____ times for ____ ☐days/☐ hours total
3) Improvement since last treatment: _____%

Pain medication:
☐ Increase ☐ Decrease ☐ No Change ☐ N/A
Self-healing methods used:
☐ Stretching ☐ Exercise ☐ Cold pack ☐ Heat pack
Do you see other providers: ☐ Yes ☐ No



Please mark on the diagram to the left the following symbols as they relate to your symptoms (use note section if not able to mark on diagram):
SP=sharp pain
SH=shooting pain
SS=spasms
ST=stiffness
DP=dull pain
TI=tingling
NU=numbness
O=other

Other Notes (pregnancy, new medication or supplements, recent surgeries, etc.)**:**

Patient Signature: _____ Date: _____

