FOLLOW-UP ASSESSMENT

Patient Name _____ Today's Date _____

HEALTH ISSUE(S) / SYMPTOM(S) / PAIN YOU ARE TARGETTING WITH ACUPUNCTURE

Problem / Issue 1: _____

Problem / Issue 2: _____

YOUR PROGRESS (How are you doing?)

Problem / Issue 1: Worse No change Somewhat better Significantly better Symptoms resolved

Problem / Issue 2: Worse No change Somewhat better Significantly better Symptoms resolved

ONGOING TREATMENT(S)

MEDICATION(S) _____ Helping? N Y

OTHER TREATMENTS Chiropractic Physical therapy Massage Injections Helping? N Y

CHANGES SINCE YOUR LAST VISIT (Please provide details)

PCP, ER, URGENT CARE VISIT(S) N Y _____

NEW INJURY / RE-INJURY N Y _____

SPECIALIST(S), IMAGING N Y _____

LET'S TALK ABOUT YOUR PAIN (IF ANY) OVERALL (please circle)

FREQUENCY / TIMING Occasional Frequent Lasts minutes Lasts hours Constant

BEST PAST WEEK 0 1 2 3 4 5 6 7 8 9 10

WORST PAST WEEK 0 1 2 3 4 5 6 7 8 9 10

WHAT HELPS Acupuncture Other therapy Medications Rest Movement Ice Heat

WHAT MAKES IT WORSE Sitting Standing Movement Bending Turning Straining Wind Cold

NOW LET'S GET MORE DETAIL ABOUT YOUR PAIN / SYMPTOMS (please circle & explain)

GENERAL	Energy	Concentration	Sleep	Mood	_____
HEAD / SCALP	Pain				_____
FACE / JAW	Pain	Swelling			_____
NECK	Pain	Stiffness	Restriction	Spasm	_____
UPPER BACK	Pain	Stiffness	Restriction	Spasm	_____
SHOULDER	Pain	Stiffness	Restriction	Swelling	_____
ELBOW	Pain	Stiffness	Restriction	Swelling	_____
WRIST	Pain	Stiffness	Restriction	Swelling	_____
HAND	Pain	Stiffness	Restriction	Swelling	_____
MID BACK	Pain	Stiffness	Restriction	Spasm	_____
LOW BACK	Pain	Stiffness	Restriction	Spasm	_____
HIP	Pain	Stiffness	Restriction	Swelling	_____
KNEE	Pain	Stiffness	Restriction	Swelling	_____
ANKLE	Pain	Stiffness	Restriction	Swelling	_____
FOOT	Pain	Stiffness	Restriction	Swelling	_____

HOW MUCH DO YOUR PAIN / SYMPTOMS INTERFERE WITH YOUR LIFE / DAILY ACTIVITIES?

No interference Some interference Unable to carry on any activities

REVIEW OF SYSTEMS

GENERAL	KIDNEY, BLADDER
☐ Feeling tired, sleepy	☐ Blood in urine, kidney disease
☐ Recent weight loss or gain	☐ Frequency, urgency, burning
☐ Always hot or cold	☐ Urine loss with coughing
☐ Night fever and/or sweats	☐ Dark concentrated urine
☐ Other	☐ Other
HEAD, EYES, EARS, NOSE, THROAT	**MEN'S HEALTH**
☐ Headache, facial pain	☐ Weak stream, straining to urinate
☐ Poor vision or other eye problems	☐ Waking up at night to urinate
☐ Hearing loss	☐ Weak erections
☐ Ear pain, hearing loss, ringing in ears	☐ Testicular pain, swelling
☐ Nasal obstruction, congestion, allergies	☐ Penile discharge, sores, warts
☐ Mouth sores, dryness	☐ Other
☐ Dental or jaw problems	
☐ Hoarseness, sore throat, inflamed neck glands	**WOMEN'S HEALTH**
☐ Other	☐ Breast tenderness, lumps
	☐ Vaginal discharge, odor, bleeding
LUNGS, BREATHING	☐ Abnormal menstruation
☐ Cough, phlegm	☐ Other
☐ Shortness of breath, COPD, asthma	
☐ Snoring	**BLOOD, IMMUNE**
☐ Other	☐ Lymph node swelling
	☐ Bruise easily, on anticoagulants
HEART AND CIRCULATION	☐ Blood disorder, anemia, cancer
☐ Chest pain and/or losing breath with activity	☐ Other
☐ High blood pressure	
☐ Heart attack, stents, bypass	**NERVOUS SYSTEM**
☐ Skipped heart beats, palpitations, pacemaker	☐ Dizziness, fainting
☐ Buttocks, calves cramping, cold feet	☐ Epilepsy, seizures
☐ Ankle, feet swelling	☐ Tingling, numbness
☐ Varicose veins, ankle discoloration	☐ Stroke, spasticity, tremors
☐ Other	☐ Balance issues
	☐ Other
STOMACH, DIGESTION	
☐ Heartburn, acid reflux, indigestion	**SKIN, HAIR**
☐ Nausea, bloating after meals	☐ Rashes, eczema, dryness
☐ Constipation or diarrhea	☐ Wounds, sores, swelling
☐ Liver disease	☐ Hair loss
☐ Blood in stool, black stool	☐ Nail problems
☐ Rectal bleeding, hemorrhoids	☐ Other
☐ Other	
	MENTAL HEALTH
ENDOCRINE	☐ Anxiety, depression, stress
☐ Diabetes	☐ Mood swings, irritability
☐ Thyroid issues	☐ Insomnia
☐ Other	☐ Other

Sign Name: _____ Date: _____