American Specialty Health (ASH)
P. O. Box 509001, San Diego, CA 92150-9001
FAX: 877.248.2746

PATIENT PROGRESS

Patient completes this form. Acupuncture and Oriental Medicine

For questions, please call ASH at 800.972.4226

PLEASE PRINT LEGIBLY

Patient Name____

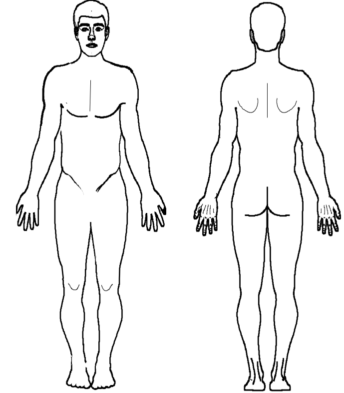
Patient, please complete the following questions regarding how you feel today and in the past week.

1. How do you feel today?

Circle your pain level today.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



In the past week, how often have your symptoms been present?

☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% ☐ None

Circle your average pain level over the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Circle your worst pain level over the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Currently, how much has your pain interfered with your daily activities?

No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

What are your goals for your acupuncture treatments?

____

How do you track your progress towards your goals?

____

What progress has been made toward your goals?

____

2. Are you getting better?

Current Condition(s)/Complaint(s)	Rate your overall progress since starting acupuncture
1____________________	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Worse
2____________________	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Worse
3____________________	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Worse

3. Which type(s) of treatment have been helpful to your condition(s)?

☐ Acupuncture treatment ☐ Nutritional supplements ☐ Rehab Exercise/Home Care
☐ Chinese herbs ☐ Prescription Medication(s) ☐ Spinal Adjustment/Manipulation
☐ Therapeutic Massage ☐ Physical therapy ☐ Other____________________

4. Is there anything new?

Have you had any new complaints/conditions? ☐ No ☐ Yes Explain____________________

Have you had any re-injuries or events that have prolonged your recovery? ☐ No ☐ Yes

Explain____

Are you pregnant? ☐ No ☐ Yes; How many weeks?_____ Are you under a physician's care? ☐ No ☐ Yes

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature______________________________ **Date**____________________