

Patient Progress Note

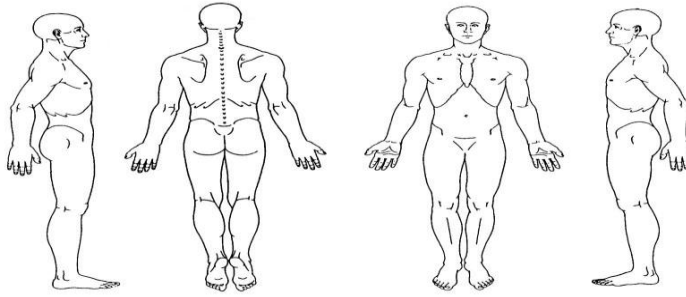
Please fill out form at each visit and return to the front desk assistant when finished. Thank you for your assistance.

Patient Name _____ Date _____

Please mark the area where there is pain.

X=Sharp Pain

O=Dull Pain



Please mark the level of intensity of your symptoms using the following scale.
(0 equals no symptom at all, 100 equals maximum possible intensity of the symptom.)

Symptom _____ 0 10 20 30 40 50 60 70 80 90 100

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Symptom _____ 0 10 20 30 40 50 60 70 80 90 100

Please rate by circling your overall state of wellness since your last treatment

Significantly Improved Improved Unchanged Worsened Significantly Worsened

(Office Use Only)

PATIENT'S NOTES

Units:	Set: 1	2	3	4
Needle #				
LV				
GB				
HT				
SI				
PC				
SJ				
SP				
ST				
LU				
LI				
KD				
UB				
REN				
DU				
EXTRA				
ASHI				
SCALP				
EAR				
MOXA/TDP				
TUINA/CUP				

What has changed?

Do you have any health concerns that you would like to communicate to the doctor other than those for which you are currently being treated for? If yes, please describe:

(Check here if documenting any physician notes on reverse) Physician's Signature: _____