**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** |
| **Symptom**  | **0** | **10** | **20** | **30** | **40** | **50** | **60** | **70** | **80** | **90** | **100** |
| **Symptom**  | **0** | **10** | **20** | **30** | **40** | **50** | **60** | **70** | **80** | **90** | **100** |
| **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?

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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:

O (Check here if documenting any physician notes on reverse) Physician’s Signature: