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

PATIENT PROGRESS

Patient completes this form. (Acupuncture)

For questions, please call ASH Networks at 888.226.8879

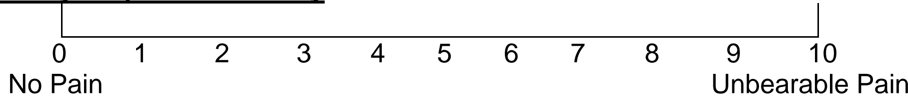
PLEASE PRINT LEGIBLY

Patient Name ____

Patient, please complete the following questions regarding how you feel today.

1. How do you feel today?

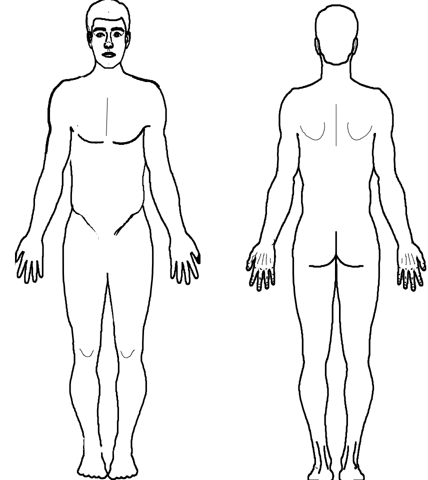
Circle your pain level today



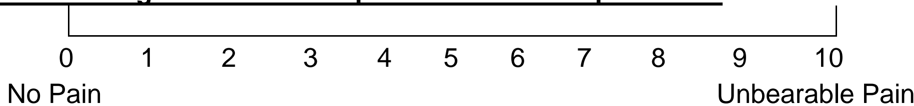
0 1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain

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



Circle average and the worst pain level over the past week



0 1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain

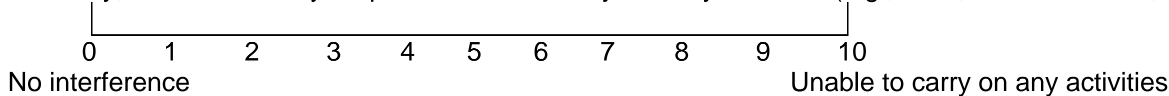
2. Are you getting better?

Current Condition(s)/Complaint(s)	Rate your overall progress since starting care	
1. ______________________	________ %	(0% = No improvement and 100% = Fully recovered)
2. ______________________	________ %	(0% = No improvement and 100% = Fully recovered)
3. ______________________	________ %	(0% = No improvement and 100% = Fully recovered)

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

(Intermittent) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

Currently, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?)



0 1 2 3 4 5 6 7 8 9 10

No interference — Unable to carry on any activities

Which type(s) of treatment appear to be most helpful to your condition(s)?

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

3. Is there anything new?

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

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

Explain: ____

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

Patient Signature: ______________________ **Date:** ______________________