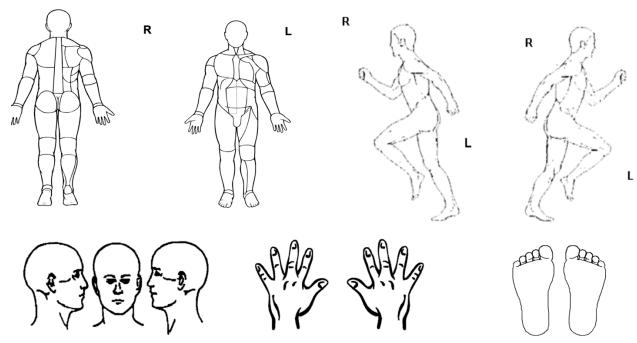
CORNERSTONE ACUPUNCTURE INSTITUTE

15785 Laguna Canyon Road Suite 330, Irvine, CA 92618
150 Laguna Canyon Road Suite A, Fullerton, CA 92835
Tel. 949-424-6430 Fax. 949-612-0010

Mark an "X" on the figure below where your pain starts and show where it goes with an arrow.



Intensity of Pain

On a scale of 0-10, with 10 being the worst pain and 0 the absence of pain, how would you rate your pain?

| At Worst: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|-----------|---|---|---|---|---|---|---|---|---|---|----|
| At Best: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Average: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

PAST MEDICAL HISTORY

Please list the medications you are currently taking:

| Name | Dosage | Frequency or As Needed |
|------|--------|------------------------|
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| Have you visited any healthcare providers in the past 4-6 weeks? If so, which provider(s)? |
|---|
| () Family Physician () Physical Therapist () Orthopedic/Spine Surgeon () Pain Management |
| () Neurologist () Rheumatologist () Rehabilitation Medicine () Chiropractor () Acupuncturist |
| () Massage Therapist () Other(s) |
| What was the reason for your visit? |
| () Evaluation () Medication () Procedure/Injection () Testing () Others |
| Have you had any following studies in the last 4-6 weeks? |
| () X-ray () MRI () CT Scan () EMG test () Ultrasound () Others |
| For which body part |
| Name of the office |
| I attestthat the information provided above is true and correct. |
| Date |
| Patient Name |
| Signature |