Standardised data collection form

Location ID –

Section 1: *Please complete Questions 1 to 7 and return this form to your Physiotherapist.*

1. Age: ☐☐ **2**. Gender: Male ☐ Female ☐

3. Occupation (Tick one box only): Student ☐ Working ☐ Not working ☐ Retired ☐

4. Please tick one box that best describes your symptoms: Back pain only ☐ Back and leg pain ☐

5. How long you have been having symptoms *(please use most appropriate box)*: weeks ☐☐ months ☐☐ years ☐☐

6. In the past week (on average) how was your pain? *(Please circle one number only)*

No Pain at all — Worst Pain ever

0	1	2	3	4	5	6	7	8	9	10

7. How much does this pain interfere with your normal activities inside and outside the home? *(Please circle one number only)*

Work normally — Unable to work at all

0	1	2	3	4	5	6	7	8	9	10

Section 2: *(to be completed by the Physiotherapist)*

8. Pain type: Acute ☐ Sub-acute ☐ Chronic ☐ Persistent/recurrent ☐

9. Treatments used *(tick all relevant)*:

Acupuncture ☐ Exercise ☐

Manual Therapy ☐ Other ☐ *Please give details*.....

10. Was acupuncture offered? Yes ☐ No ☐ *If **No** go to Question 19*

11. If yes, was acupuncture declined? No ☐ Yes ☐ *If **Yes** why?* .....*Now go to Q 19*

12. Was consent form signed? Yes ☐ No ☐

13. Type of acupuncture treatment used:

Western approach ☐ TCM ☐

Dry needling ☐ Trigger point ☐

Combined TCM & Western ☐ Electro-acupuncture ☐

Auricular ☐ Other ☐

Please specify other .....

14. Dose/time needles in situ: Less than 20 minutes ☐ 20-30 minutes ☐ 30+ minutes ☐

15. De Qi achieved? Yes ☐ No ☐ NA ☐ **16**. Number of acupuncture treatments ☐☐

17. Any adverse reactions to acupuncture? Yes ☐ No ☐ *If **yes**, please specify* .....

18. Frequency of acupuncture treatment: Weekly ☐ Fortnightly ☐ Monthly ☐ Irregularly ☐

19. Treatment complete: Yes ☐ No ☐ **20**. Total number of treatments ☐☐ **21**. Overall duration of treatment ☐☐ weeks

Section 3: Outcomes *(To be completed by client/patient)*

22. In the past week (on average) how was your pain? *(Please circle one number only)*

No Pain at all — Worst pain ever

0	1	2	3	4	5	6	7	8	9	10

23. How much does pain interfere with your normal activities inside and outside the home? *(Please circle one number only)*

Work normally — Unable to work at all

0	1	2	3	4	5	6	7	8	9	10

24. How satisfied are you with the **delivery** of your treatment? *(Please circle one number only)*

Completely dissatisfied — Completely satisfied

0	1	2	3	4	5	6	7	8	9	10

25. How satisfied are you with the **outcome** of treatment? *(Please circle one number only)*

Completely dissatisfied — Completely satisfied

0	1	2	3	4	5	6	7	8	9	10

Additional information: .....