

Patient Testimonial Worksheet

The story of your experience with acupuncture is a powerful tool for us to share with legislators and the public to increase their awareness of acupuncture. Your testimonial is an important advocacy tool to gather support for HR 4803, the Acupuncture for Our Seniors Act.

This worksheet is intended as a guide to organize your thoughts and assist you in writing your testimonial. An effective testimonial includes the details of your experience, and results, with your acupuncture treatments. You can use the answers to these questions to write your testimonial, in your own words, on the last page of this form.

Thank you for sharing your story and helping us to increase the awareness of the benefits of acupuncture and the valuable role of licensed acupuncturists in healthcare.

Full Name: _____

Mailing Address (city, state, zip code): _____

1. Why did you seek treatments from a licensed acupuncturist? _____

2. How long had you experienced this problem? _____

3. Was your primary reason for seeking acupuncture due to pain? Yes No

4. Please rate the level of your pain before you began receiving acupuncture treatments on a scale of 0-10. (0= mild discomfort that doesn't interfere with work or activity, 10=extreme pain that prohibits work or other activity) _____

5. Before receiving acupuncture did your pain limit your performance or participation in any of the following? (Select all that apply)

Sitting

Bending

Lifting

Standing

Walking

Working

Sleeping

Driving a car

Recreational activities

Social activities

Other _____

Please provide any additional details: _____

6. Were you taking pain medications previous to acupuncture treatments? If so, has the amount, frequency, or type of pain medications needed to control your pain changed since receiving your acupuncture treatments? Please list the medication(s) and the frequency that you were taking the medication(s) before and after acupuncture treatments. _____

7. Please rate the level of your pain since receiving acupuncture on a scale of 0-10. (0= mild discomfort that doesn't interfere with work or activity, 10=extreme pain that prohibits work or other activity)

8. Since receiving acupuncture did you experience improvements in your performance or ability to participate in any of the following? (Select all that apply)

- | | | |
|-------------------|---------------|-------------------------|
| Sitting | Bending | Lifting |
| Standing | Walking | Working |
| Sleeping | Driving a car | Recreational activities |
| Social activities | Other _____ | |

Please provide any additional details: _____

9. Are there any other ways that your acupuncture treatments have improved the quality of your life? _____

10. Was the cost of acupuncture treatments covered by your insurance? Yes No

11. Did the cost of treatment prevent you from completing the recommended number of treatments? Yes No

12. Are you currently enrolled in one of these Medicare plans?

- | | | |
|----------------------|--------------------|--------------------------|
| Traditional Medicare | Medicare Advantage | Not enrolled in Medicare |
|----------------------|--------------------|--------------------------|

13. Is there anything else you would like to share about your experience, or the results, of your acupuncture treatments? _____
