



# Acupuncture & Wellness of Wisconsin, Ilc

## Patient Treatment Goals

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

1.) What is your primary reason for seeking care at Acupuncture & Wellness of Wisconsin? \_\_\_\_\_

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2.) What is your number one goal for your treatment outcome? \_\_\_\_\_

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3.) What is your secondary goal for your treatment outcome? \_\_\_\_\_

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4.) Do you have any other health concerns that you would like to have addressed? If yes, what are they? \_\_\_\_\_

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5.) What other steps are you taking to resolve your concern? \_\_\_\_\_

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6.) What, if any, other approaches have helped reduce or alleviate your symptoms? \_\_\_\_\_

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**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Office Use Only:

Reassess:	Tx:	Practitioner Signature:	Date: