Blind Method Assessment Questionnaire

Name: ___________  Random number: ___________  Date: ___________

Please answer the following questions according to your latest acupuncture experience.

1. How’s your feel about needle sensation (sensations induced by acupuncture, like sourness, numbness, distending, heaviness, etc)?

Please ring a number between 0 (no needle sensation) and 10 (unbearable needle sensation).

[Scale from 0 to 10 with None on the left and Unbearable on the right]

2. Do you have acupuncture experience?  (Yes  No)

3. Do you have electroacupuncture experience?  (Yes  No)

4. Do you think you are needed at acupuncture points?  (Yes  No)

5. Are you sure you are receiving acupuncture treatment?  (Yes  No)