

ACUPUNCTURE/HERBS EVALUATION FORM

Please fill this form out as completely as possible. The information you give helps me to understand your condition more fully. All information provided is confidential. Please print clearly.

DEMOGRAPHIC

Name: Age: Birth Date: / /

Street Address:

Street Address:

City: State: Zip: -

Email:

Day Phone: - -

Evening Phone: - -

Mobile Phone: - -

Occupation:

Emergency Contact Name: Emergency Contact Phone: - -

Physician Name: Physician Phone: - -

Insurance Company Name:

Insurance Company Phone: - - Insurance Policy ID:

Referred by [How did you hear about us]:

MEDICAL HISTORY

Please describe any major injuries, illnesses, or surgery:

Please identify if you experience any of the following:

<input type="checkbox"/> -alcoholism	<input type="checkbox"/> -Emphysema	<input type="checkbox"/> -lymph node removal	<input type="checkbox"/> -seizures
<input type="checkbox"/> -allergies	<input type="checkbox"/> -Heart Disease	<input type="checkbox"/> -MS	<input type="checkbox"/> -Tuberculosis
<input type="checkbox"/> -asthma	<input type="checkbox"/> -Hepatitis A -B -C	<input type="checkbox"/> -pacemaker	<input type="checkbox"/> -other
<input type="checkbox"/> -birth trauma	<input type="checkbox"/> -Herpes	<input type="checkbox"/> -Polio	<input type="text"/>
<input type="checkbox"/> -cancer	<input type="checkbox"/> -HIV/AIDS	<input type="checkbox"/> -Rheumatic Fever	
<input type="checkbox"/> -Diabetes	<input type="checkbox"/> -latex allergy	<input type="checkbox"/> -Scarlet Fever	

Family Medical History

Siblings	<input type="text"/>
Father	<input type="text"/>
Mother	<input type="text"/>
Grandparents	<input type="text"/>

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RESPIRATORY

☉ Do you have or have had often:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> -asthma | <input type="checkbox"/> -cough with mucus | <input type="checkbox"/> -nose bleeds | <input type="checkbox"/> -poor/blurred vision |
| <input type="checkbox"/> -bleeding gums | <input type="checkbox"/> -dizziness/Vertigo | <input type="checkbox"/> -pain inhaling | <input type="checkbox"/> -ringing in the ears |
| <input type="checkbox"/> -chronic cough | <input type="checkbox"/> -ear pain | <input type="checkbox"/> -painful/red eyes | <input type="checkbox"/> -shortness of breath |
| <input type="checkbox"/> -chronic runny nose | <input type="checkbox"/> -frequent colds | <input type="checkbox"/> -poor hearing | <input type="checkbox"/> -other |

☉ Do you smoke? -Yes -No If yes, how much? If yes, years smoking?

CARDIOVASCULAR & NEUROLOGICAL

☉ Blood pressure: /

☉ Have you been diagnosed with a heart condition? -Yes -No

☉ Do you have or have had often:

- | | | |
|--|---|--|
| <input type="checkbox"/> -arrhythmia | <input type="checkbox"/> -cold hands/feet | <input type="checkbox"/> -poor Circulation |
| <input type="checkbox"/> -burning sensations | <input type="checkbox"/> -numbness/Tingling | <input type="checkbox"/> -varicose veins |
| <input type="checkbox"/> -chest pain | <input type="checkbox"/> -palpitations | <input type="checkbox"/> -other |

EMOTIONS & SLEEP

☉ How do you feel emotionally?

☉ Where do you hold stress?

☉ How do you relax?

☉ How do you feel about your:

Work:

Relationships:

☉ Do you use: -antidepressants -non-prescription drugs -recreational drugs

☉ Do you experience:

- | | | |
|--------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> -bad temper | <input type="checkbox"/> -difficulty concentrating | <input type="checkbox"/> -poor memory |
| <input type="checkbox"/> -depression | <input type="checkbox"/> -panic attacks | |

☉ How many hours do you sleep per night?

☉ Do you have problems with: -disturbed sleep -falling asleep -staying asleep

-waking at because

SKIN & HAIR

☉ Do you have or have had often:

- | | | | |
|------------------------------------|-------------------------------------|---|---------------------------------|
| <input type="checkbox"/> -acne | <input type="checkbox"/> -edema | <input type="checkbox"/> -itching | <input type="checkbox"/> -other |
| <input type="checkbox"/> -dry skin | <input type="checkbox"/> -hair loss | <input type="checkbox"/> -premature graying | <input type="text"/> |
| <input type="checkbox"/> -eczema | <input type="checkbox"/> -hives | <input type="checkbox"/> -rashes | |

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URINARY & GENITAL

☉ Urination: how often daily ; color: -pale yellow -dark yellow -orange

☉ Do you have or have had often:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> -blood in urine | <input type="checkbox"/> -incontinence | <input type="checkbox"/> -painful intercourse | <input type="checkbox"/> -urinary tract infections |
| <input type="checkbox"/> -burning sensation | <input type="checkbox"/> -infertility | <input type="checkbox"/> -trouble holding urine | |
| <input type="checkbox"/> -frequent urination | <input type="checkbox"/> -pain urinating | <input type="checkbox"/> -trouble starting urine | |

☉ How is your sexual energy?

☉ Used method of birth control?

MEN: ☉ Do you have or have had often: -prostatitis -impotence

WOMEN:

☉ Are you pregnant? -Yes -No

☉ Are you trying to conceive? -Yes -No

☉ Menstruation began at age ; cycle is days; flow is days; color

☉ Describe any PMS symptoms

☉ Describe any menopausal symptoms

☉ Number of deliveries miscarriages abortions

☉ Do you have or have had often:

- | | | |
|--|--|---|
| <input type="checkbox"/> -breast discharge | <input type="checkbox"/> -irregular cycles | <input type="checkbox"/> -pain during cycle |
| <input type="checkbox"/> -clots | <input type="checkbox"/> -light flow | <input type="checkbox"/> -vaginal discharge |
| <input type="checkbox"/> -heavy flow | <input type="checkbox"/> -missed cycles | |

MUSCLE, JOINTS, & BONES

☉ Describe the location of your pain

☉ Describe the pain itself

☉ The pain is -achy -burning -deep -dull -numb -sharp

☉ Better with -touch -heat -cold

☉ Worse with -touch -heat -cold

☉ Do you have or have you often had

- | | | | |
|-------------------------------------|--|--|--------------------------------------|
| <input type="checkbox"/> -arthritis | <input type="checkbox"/> -muscle cramps/pain | <input type="checkbox"/> -rheumatism | <input type="checkbox"/> -tendonitis |
| <input type="checkbox"/> -bone pain | <input type="checkbox"/> -repetitive strain | <input type="checkbox"/> -swollen joints | <input type="checkbox"/> -other |
-

ACUPUNCTURE/HERBS EVALUATION FORM

CONDITION DETAILS

- ☉ What do you want treated with acupuncture?
- ☉ How long have you experienced this condition?
- ☉ Was this condition's onset -gradual or -sudden?
- ☉ Your symptoms are relieved by?
- ☉ Your symptoms are worsened by?
- ☉ Please describe any of your conditions which require medications:
- ☉ In the diagram below, please indicate the areas which you would like to have addressed:

