

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.

Name _____ Age _____

What do you want treated with acupuncture _____

How long have you had this condition? _____ Onset was Sudden/Gradual

Symptoms relieved by: _____

Symptoms worsened by: _____

What medical diagnosis have you received? _____

Other treatments you received recently _____

What medications are you taking and for what condition:

Are you pregnant? _____ Trying to conceive? _____

Medical History

Dates and major injuries, illness, or surgery

Please circle any existing conditions:

- | | | |
|---------------|--------------------|-----------------|
| Alcoholism | Hepatitis A/B/C | Polio |
| Allergies | Herpes | Rheumatic fever |
| Asthma | HIV/AIDS | Scarlet fever |
| Birth trauma | Latex Allergy | Seizures |
| Cancer | Lyme disease | Tuberculosis |
| Diabetes | Lymph node removal | Other: |
| Emphysema | MS | _____ |
| Heart disease | Pacemaker | _____ |

Phone numbers

Day _____

Even _____

Address _____

Date of Birth _____

Occupation _____

Referred by _____

Emergency Contact

Phone _____

Physician _____

Phone _____

Insurance _____

ID # _____

Signature _____

Date _____

Family Medical History

Father _____ Grandparents _____

Mother _____

Siblings _____

DIET

How is your appetite _____ How often do you have: Coffee/Tea _____ day/week
Any food cravings _____ Sugar/Sweets _____ day/week Alcohol _____ day/wk
Any food intolerance _____ Rate your preference: (1-lowest 5-highest)
Vitamins/minerals you take: _____ Sour ___ Bitter ___ Sweet ___ Spicy ___ Salty___

Are you thirsty? _____ Typical Meals:
Breakfast _____
Do you prefer: hot / cold drink Lunch _____
Dinner _____

GASTROINTESTINAL

Bowel movements: Painful? ___ How often? ___ day/week
Do you often have or have had often (circle)
Abdominal pain Diarrhea Undigested food in stool Hemorrhoids
Hypochondriac pain Loose stools Blood in stools Hernia
Nausea/Vomiting Hard stools Heartburn Indigestion
Constipation Belching Acid reflux Gas
Use laxatives Other: _____

EXERCISE & ENERGY

How is your energy level? _____ What kind of exercise do you do? _____
When is your energy highest? _____ Lowest? _____
Do you fatigue easily? _____ How often do you exercise? _____

RESPIRATORY/ENT

Do you have or have had often? (circle)
Frequent colds Asthma Painful/red eyes Ringing in the ears
Chronic runny nose Pain inhaling Poor/blurred vision Poor hearing
Chronic cough Shortness of breath Dizziness/Vertigo Bleeding gums
Cough with blood Nose bleeds Ear pain Cough with mucus
Sore/dry throat Do you smoke? ___ How much? _____ For how long? _____

CARDIOVASCULAR/NEUROLOGICAL

Blood pressure ____/____

Have you been diagnosed with a heart condition?

Do you have or have had often: (circle)

Chest pain

Poor circulation

Palpitations

Cold Hands/Feet

Arrhythmia

Numbness/Tingling

Varicose veins

Burning sensations

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?

Non-prescription drugs Antidepressants

Recreational drugs

Do you experience:

Panic attacks

Depression

Poor memory

Difficult concentration

Bad temper

How long do you sleep per night? _____

Do you have problems with?:

Falling asleep

Waking at ____ because

Staying asleep

Disturbed sleep

URINARY & GENITAL

Urination: How often? ____/day

Color: Pale yellow/ Dark yellow/ Orange

Do you have or have had often?

Frequent urination Trouble holding urine

Incontinence Trouble starting urine

Pain urinating Urinary Tract infections

Burning sensation Blood in Urine

Painful intercourse Infertility

How is your sexual energy? _____

What kind of birth control do you use?

Women

At what age did you begin menstruation? _____

Cycle ____ days

Menses ____ days

Color _____

PMS Symptoms _____

Menopausal symptoms _____

Do you have or have had often (circle)

Irregular menses

Pain around menses

Heavy/ Light flow

No menses

Clots

Discharge from breasts

Vaginal discharge

Number of deliveries ____ Miscarriages/Abortions ____

Men

Do you have or have had often (circle):

Prostatitis Impotence

SKIN & HAIR

Do you often have or have often had

Dry Skin	Skin Rashes	Eczema	Itching	Premature Graying
Edema	Acne	Hives	Hair Loss	_____

MUSCLE, JOINTS & BONES

Where is your pain _____

* Shade the areas that you would like to have addressed

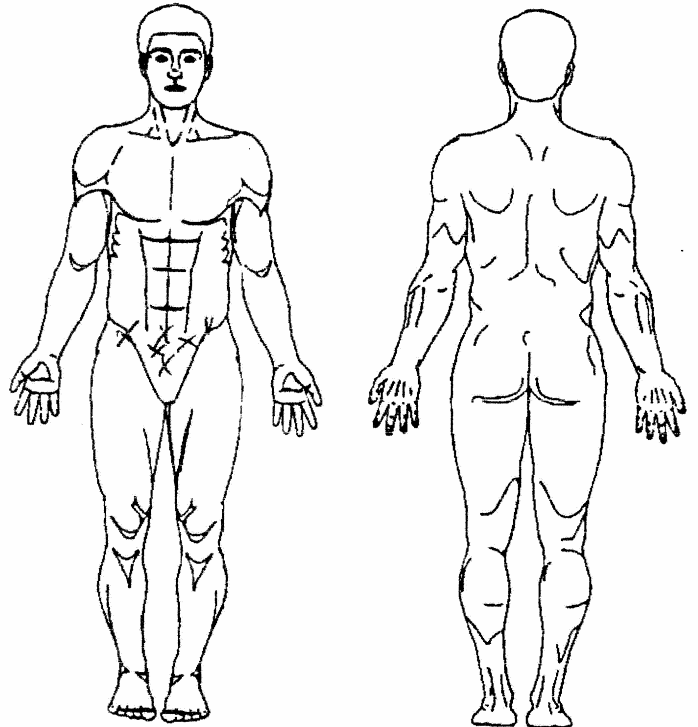
The pain is:

Sharp	Numb	Dull
Achy	Burning	Deep

Better / Worse with Touch
Better / Worse with Heat
Better / Worse with Cold

I have:

Swollen Joints	Muscle Cramps/Pain
Arthritis	Bone Pain
Tendonitis	Repetitive Strain
Rheumatism	_____



Thank You