INITIAL EVALUATION FORM

Patient's Name ______________________________ Date ________________
Address ____________________________________ Phone _______________
City/State/Zip ______________________________ Work Phone ___________
Gender _____ Age _____ Weight _____ Height _____ Date of Birth ______________
SS# ____________________ Email Address __________________________

Insurance Carrier ____
Policy Holder ______________________________ Policy Holder DOB __________
Emergency Contact __________________________ Phone _________________
Family Physician ___________________________ Phone _________________
Specialist (if relevant) ______________________ Phone _________________
How did you hear about us? ____

Current Medical History

Primary Reason for Visit ____
____
Other concerns you would like to address _______________________________
____
How long have you had your problem? __________________________________
Has a physician given you a diagnosis? __________________________________
Have you had MRI, XD ray, lab tests for this condition________________________

(if you have had any of the above, please bring the written report to your initial visit, if possible, to assist in a complete evaluation. If there are metal implants, fusions, screws, etc. please bring the actual films)

What was the initial cause? ____
Is it getting worse? _____ How so? ____________________________________
What makes your condition better? ____________________________________
What makes it worse? ____
Is it worse at certain times of year? _____________Certain weather? _________
What treatments are you currently using? _______________________________
Are they effective? ____
What treatments have you tried in the past? _____________________________
Were they effective? ____
Current Medications/Supplements _____________________________________
____
____

Past Medical History

Surgeries/Medical Procedures *(include dates)* _____________________________
____
____
____

Past Physical Traumas *(e.g. car accident, fall, childhood injuries)* ____________________________
____
____

Past Emotional Traumas *(e.g. divorce, death in family, childhood trauma)* ____________________
____
____

Past Medications *(e.g. Chemotherapy, Steroids, Childhood antibiotics)* ________________________
____
____

Check any of the following conditions you have currently or have had in the past

____ Auto-immune
____ Appendicitis
____ Alcoholism
____ Allergies
____ Antibiotic use
____ Appendicitis
____ Arthritis
____ Asthma
____ Birth trauma
____ Bleeding disorder
____ Blood clots
____ Bronchitis
____ Chicken pox
____ Cancer *(specify)*
____
____
____ Diabetes
____ Depression
____ Emphysema
____ Gall bladder disorder
____ Glaucoma
____ Gout
____ Heart disease
____ Headaches
____ Hepatitis
____ Herpes
____ Hypertension
____ IBS
____ Jaundice
____ Kidney disorder
____ Liver disorder
____ Measles
____ Mononucleosis
____ Multiple Sclerosis
____ Mumps
____ Nervous disorder
____ Osteoporosis
____ Pacemaker
____ Parasites
____ Phlebitis
____ Pneumonia
____ Seizures
____ STD's
____ Stroke
____ Thyroid disorder
____ Tuberculosis
____ Vascular disease
____ Ulcers
____ Other *(Specify)*
____
____

Family Medical History

Father: Alive/Age _____ Deceased/Age _____
Father health issues ____
Mother: Alive/Age _____ Deceased/Age _____
Mother health issues ____
Your birth order *(e.g. 3rd child of 5)* ____
Siblings *(total #/health issues)* ____
____
____

Other relevant family information ____
____
____
____

Lifestyle

Occupation ______________________________ Hours per week _____ Stress level _______
Physical or other stressors form occupation ____
____

Married/partnered ______ Single ______
Hobbies/activities ____
Exercise *(what type, how often)* ____
After exercise, do you feel: Better ____ Worse ____ About the same ____
Energy level in general *(1-10)*____ Time of day more energy ____ Time of day less ____
How much sleep on average _____________ Night owl ____ Morning person ____
Alcohol frequency _____________
Tobacco frequency ____________
Caffeine frequency ____________
Recreational drugs frequency ____________
Social support *(family, friends, social organizations)* _______________________________________
____

Nutrition

Your appetite: Good ____ Fair ____ Poor ____ Fluctuates ____ Hungry w/no app ____
Do you eat: 3 meals/day ____ More frequent small meals ____ irregular meals ____
Do you eat breakfast? ____ Are you a vegetarian? ____ Times/week you eat out ____

What do you eat on a typical day?

Breakfast ____
Lunch ____
Dinner ____
Snacks ____

Cravings

Sweet ____ Chocolate ____ Pasta ____
Salty ____ Cheese ____ Other *(specify)* _______
Sour ____ Bread ____ _____________________

Please provide any additional information about your diet that you feel is relevant *(foods you feel are best for you, foods you have adverse reactions/allergies/sensitivities to, foods you dislike, etc.)* ____
____
____
____

Psychological/Emotional

Circle the number that best applies to you:

	Rarely		*Neutral*	*Often*	
Wood/Liver					
Depressed	1	2	3	4	5
Angry	1	2	3	4	5
Easily irritable	1	2	3	4	5
Lack of courage	1	2	3	4	5
Indecisive	1	2	3	4	5
Fire/Heart					
Laughs easily	1	2	3	4	5
Anxious, restless	1	2	3	4	5
Easily frightened	1	2	3	4	5
Earth/Spleen					
Happy, content	1	2	3	4	5
Compulsive caretaker	1	2	3	4	5
Worry, overthinking	1	2	3	4	5
Obsessive	1	2	3	4	5
Metal/Lung					
Melancholy, sad	1	2	3	4	5
Grief	1	2	3	4	5
Water/Kidney					
Fearful	1	2	3	4	5
Introverted	1	2	3	4	5
Lack of will	1	2	3	4	5

Please check any of the following conditions that you have or have had in the past:

General

General Body Temperature: ____ Cold ____ Cool ____ Temperate ____ Warm ____ Hot

Qi

____ Tired, fatigued
____ Tired after exercising
____ Spontaneous sweating
____ Wake up tired

Yang

____ Extreme fatigue
____ Chilled easily
____ Cold sweats

Qi	**Yang**

Heart

Qi

____ Palpation
____ Shortness of breath upon exertion

Yang

____ Cold limbs
____ Blue lips

Lung

Qi

____ Feeble cough
____ Shortness of breath with exertion
____ Catch colds easily
____ Aversion to wind
____ Spontaneous sweating

(*Yin?)*

____ Dry cough
____ Dry mouth and throat
____ Afternoon fever
____ Night sweating

Spleen

Qi

____ General fatigue
____ Bloating after eating
____ Tired after eating
____ Loose stools/diarrhea
____ Weakness in limbs
____ Poor appetite
____ Bleed/bruise easily
____ Heavy menstrual bleeding
____ Prolapsed organs
____ Hemorrhoids

Yang

____ Prefer warm food
____ Abdom pain better with pressure and warmth
____ Diarrhea
____ Chilly with cold limbs
____ Loose stool with undigested food

Kidney

Qi

____ Low back pain
____ Knee pain
____ Frequent urination
____ Bone fractures, weakness
____ Dental problems
____ Difficulty inhaling a deep breath
____ Rapid and weak breathing
____ Asthma

Yang

____ Frequent urination at night
____ Clear urine
____ Swollen ankles, legs
____ Impotence
____ Loose stool w/ undigested food
____ Diarrhea in early morning

Liver

Qi

____ Mental depression
____ Irritability
____ Sighing
____ Flank pain and pain below ribs
____ Foreign body sensation in throat
____ Dysmenorrhea
____ Breast distension

Fire

____ Pain in head
____ Eye redness, swelling, pain
____ Bitter taste in mouth
____ Irritable

Liver (con't)

Yang rising	**Wind**
____ Headache	____ Itching
____ Dizziness	____ Pain that moves to various parts

Liver and Gallbladder (Damp-heat)

____ Scanty yellow urine	____ Yellow whites of eyes and skin
____ Bitter taste in mouth w/ poor appetite and nausea	____ Swelling, burning in genitals

Yin	**Blood**

General

____ Feel warm in afternoon	____ Dizziness/vertigo
____ Feel warm in evening	____ Dry skin, hair, nails
____ Hot flashes	____ Numbness/tingling in hands or feet
____ Deep heat in body	____ Blurred or weak vision
____ Low grade fever in PM	____ Insufficient lactation
____ Night sweats	____ Scanty or infrequent period
____ Heat in palm of hands	
____ Heat in soles of feet	
____ Flushed face	
____ Thirsty for cold drinks	

Heart

____ Difficulty staying asleep	____ Difficulty falling asleep
____ Mental restlessness	____ Poor memory
____ Anxiety esp that builds later in day	____ Confusion

Lung

____ Dry cough	____ Rashes or hives
____ Dry throat	____ Itchy skin
____ Cough w/blood	

Liver

____ Dry eyes	____ Blurry vision
____ Heat in palms/soles of feet	____ Numbness of limbs
	____ Muscle twitches
	____ Spasms of tendons
	____ Dry brittle nails
	____ Poor night vision
	____ Floaters/spots in vision
	____ Tremor, shaking

Kidney

Yin

____ Insomnia
____ Tinnitus
____ Dizziness
____ Poor memory
____ Low back/knee pain
____ Night sweats/hot flashes

Dampness/Phlegm

____ Foggy/sluggish thinking
____ Headaches like a band around the head
____ Ear discharge
____ Cysts
____ Difficulty getting up in morning
____ Sweaty hands/feet
____ Nodules
____ Acne

Lung

____ Sinus discharge
____ Chest congestion
____ Productive cough
____ Shortness of breath or wheezing
____ Post-nasal drip
____ Sinus infections
____ Difficulty breathing lying down

Spleen

____ Nausea
____ Weight gain
____ Aversion to greasy food
____ Cysts
____ Yellow sweating (stains)
____ Fungal infections

Kidney

____ Swollen feet/ankles/legs
____ Swollen joints

Gastro-Intestinal

____ Acid reflux
____ Nausea
____ Belching
____ Flatulence
____ Stomach/abdominal pain
____ Flank pain
____ Frequency of bowel movements per day (or per week if less) ____
____ Loose stool
____ Blood in stool
____ Incomplete bowel movements

Genito-Urinary

How many times do you normally urinate per day? ______
What color is your urine normally (without taking vitamins)? ______

____ Painful urination
____ Frequent urination
____ Urgent urination
____ Dribbling after urination
____ Blood in urine
____ Incomplete urination
____ Strong-smelling urine
____ Cloudy urine
____ Kidney stones
____ Dribbling while coughing or jumping
____ Discharge
____ Bedwetting
____ Incontinence

Genito-Urinary Male

____ Prostate problems
____ Low sperm count
____ Discharges
____ Genital pain
____ Swollen testicles
____ Cold, numb genitals
____ Impotence
____ Erectile dysfunction
____ Sex drive (1-10)
____ Other (describe) ____

Genito-Urinary Female

____ Age menses began
____ Age menopause
____ Number of days in cycle
____ Duration of flow
____ Number of pregnancies
____ Number of abortions
____ Number of miscarriages
____ Pregnant currently?
____ Birth control (specify type and how long)
____

____ Infertile
____ Fibroids
____ Cysts
____ Fibroids
____ Vaginal discharge
____ Yeast infections
____ Endometriosis
____ Pain during intercourse
____ Sex drive (1-10)

Menstrual Cycle

____ Irregular (specify) ______________________________________
____ Spotting
____ PMS
____ Headaches before period
____ Headaches after period
____ Cramping, pain
____ Clots, dark blood
____ Mid-cycle bleeding
____ Water retention, bloating

Peri-menopausal symptoms

____ Depression
____ Anxiety
____ Crying spells
____ Spotting
____ Hot flashes
____ Vaginal dryness

Additional information you feel is relevant: ____
____
____

Musculo-skeletal

____ Neck pain, stiffness
____ Multiple joint pain
____ Hip pain
____ Shoulder pain
____ Sore muscles
____ Sciatica
____ Upper back
____ Arthritis
____ Low back
____ Foot pain

Muscle weakness? ____ Where? ______________________________
Muscle stiffness? ____ Where? ______________________________
Limited range of motion? ____ Where? ______________________________
Limited use/function? ____ Where? ______________________________

Please indicate on the drawings below any areas of pain, discomfort