INITIAL EVALUATION FORM
443-275-2646

Patient's Name ________________________________ Date ____________________
Address _____________________________________ Phone __________________
City _______________________**State**_____ **Zip** _________Cell ____________________
Gender _____ Age _____ Weight _____ Height _____ **Date of Birth** ________________
Email Address _____________________________ (for email reminders)
Insurance Co_____________________**Is this workman's comp/auto related?**____
Policy Holder ______________________________**Policy Holder DOB** ___________
Relation to you_____________ (if different home address, please note on side)
Emergency Contact ____________________________**Phone**______________________
Family Physician ______________________________ Phone ______________________
Specialist (if relevant) __________________________ Phone ______________________
How did you hear about us? ______________________________
Have you ever had acupuncture before? ______________

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, X-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 from 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

____ Headache
____ Dizziness

Wind

____ Itching
____ Pain that moves to various parts

Liver and Gallbladder (Damp-heat)

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

Yin / **Blood**

General

Yin

____ Feel warm in afternoon
____ Feel warm in evening
____ Hot flashes
____ Deep heat in body
____ Low grade fever in PM
____ Night sweats
____ Heat in palm of hands
____ Heat in soles of feet
____ Flushed face
____ Thirsty for cold drinks

Blood

____ Dizziness/vertigo
____ Dry skin, hair, nails
____ Numbness/tingling in hands or feet
____ Blurred or weak vision
____ Insufficient lactation
____ Scanty or infrequent period

Heart

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

Lung

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

Liver

____ Dry eyes
____ Heat in palms/soles of feet
____ Blurry vision
____ 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
____ Spotting
____ Anxiety
____ Hot flashes
____ Crying spells
____ Vaginal dryness

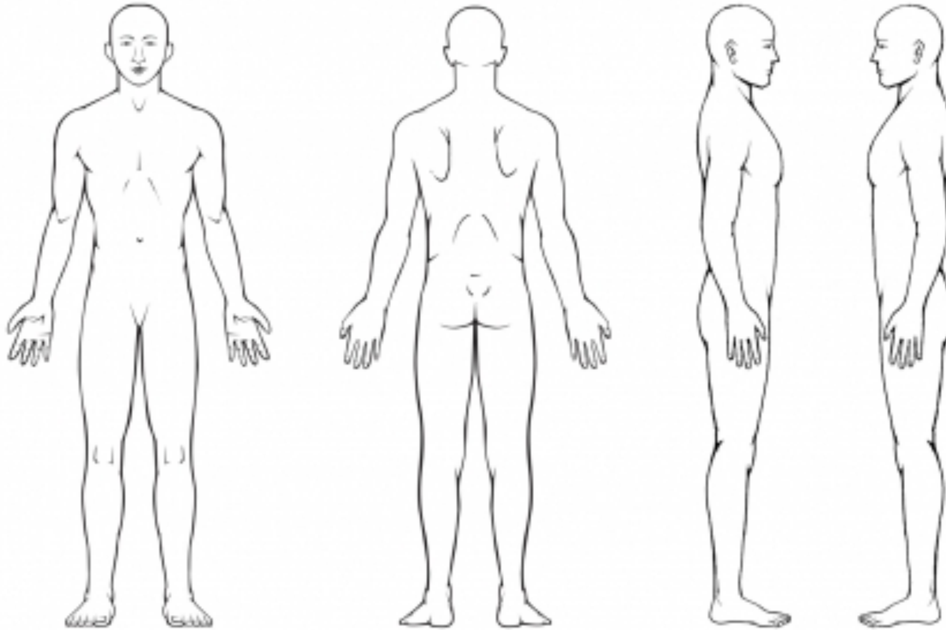
Additional information you feel is relevant: ______________________________________
____
____

Musculo-skeletal

____ Neck pain, stiffness

____ Multiple joint pain

____ Hip pain



____ Shoulder pain
____ Upper back
____ Low back

____ Sore muscles
____ Arthritis
____ Foot pain

____ Sciatica

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