Julie Senko, M.S., ATC., LAc, CSCS

Date ___________________

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 ____________________________________

Eve ____________________________________

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___

____

Typical Meals:

Are you thirsty? _________

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?

____

Men
Do you have or have had often (circle):

Prostatitis | Impotence

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 ___

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 ______________________________

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

* Shade the areas that you would like to have addressed