

EVALUATION FORM

Patti Saftan, M.S., L.Ac.
Diplomate, Board Certified Acupuncturist

Information provided on this form is confidential. PLEASE PRINT.

Patient Information			
Name	Age	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Today's Date
Address		Occupation	
City, State	Zip	Date of Birth	
Telephone - Day		Telephone - Evening	
Referred by			
Physician		Telephone	
What do you want treated with acupuncture?			
How long have you had this condition?		The onset was: <input type="checkbox"/> Sudden <input type="checkbox"/> Gradual	
Symptoms relieved by		Symptoms worsened by	
What medical diagnosis have you received?			
What other treatments have you received recently for this and/or other conditions?			
What medications are you taking?			
For what conditions?			
In general, do you feel hot or cold?		Do you have chills or fever?	

Past Medical History

Have you had any of these? Please check ALL that apply.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Lymph Nodes removed |
| <input type="checkbox"/> Birth Trauma
(your own birth) | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever | | |

Are you currently pregnant? Yes No Are you presently trying to get pregnant? Yes No

Describe any significant injuries, surgeries, or major illnesses, whether hospitalized or not, and the dates:

Diet & Food

How is your appetite?

Any food cravings?

List any food intolerances:

List any vitamins and supplements you are taking:

Describe meals for a typical day:

BreakfastLunchDinner

How often do you have:

Meat _____ Day/Week

Coffee or Tea (caffeinated) _____ Day/Week

Sugar/Sweets _____ Day/Week

Dairy (milk, cheese, yogurt) _____ Day/Week

Are you always thirsty? Yes NoDo you prefer Hot drinks OR Cold drinks?Do you have unusual sweating? Yes No

When?

Other?

How many glasses/cups do you consume daily? Water _____ Soda _____ Coffee/Tea _____ Alcohol _____ Day/Week

Rate your taste preferences 1 to 5 (1=Like Most to 5=Dislike) Salty _____ Sour _____ Bitter _____ Sweet _____ Spicy _____

Gastrointestinal

I have (check all that apply):

- Belching Nausea Vomiting Vomiting Blood Ulcers Bloating
 Acid Regurgitation Heartburn Hernia Indigestion Severe Stomach Pain
 Other _____

Bowel Movements: How often? _____ Day/Week

Painful Bowel Movements? Yes No

I have (check all that apply):

- Irregular Constipation Diarrhea Gas Burning Hemorrhoids
 Use Laxatives Undigested Food in Stool Loose Stool Hard Stool
 Blood in Stool Itchiness Other _____

Exercise & Energy

How is your energy?

What time of day is your energy: Highest-

Lowest-

Do you fatigue easily?

What kind of exercise do you do?

How often do you exercise?

Emotions & Sleep

How do you feel emotionally?

Do you have (check all that apply):

-
- Panic Attacks
-
- Depression
-
- Anxiety
-
- Bad Temper
-
- Nervousness
-
-
- Fear Attacks
-
- Poor Memory
-
- Difficult Concentration
-
- Other _____

-
- Married/Stable Relationship
-
-
- Single

How do you feel about your relationship?

How do you hold stress?

How do you relax?

How do you feel about your work?

Do you use any prescription or non-prescription substances? Anti-depressants Sleeping Pills Other _____

How long do you normally sleep? _____ hours/night

I have difficulty with (check all that apply):

-
- Falling Asleep
-
- Staying Asleep
-
- Disturbed Sleep
-
-
- Waking up at about _____ am/pm and not being able to fall asleep again because _____

Urinary & Genital

Urination: How often? _____ times per day

Color: Pale Yellow Dark Yellow/Orange

I have or have had (check all that apply):

-
- Trouble starting stream
-
- Frequent Urination
-
- Incontinence
-
- Pain
-
-
- Trouble holding urine
-
- Burning
-
- Dribbling when sneezing
-
- Urinary Tract Infections
-
-
- Blood in urine
-
- Kidney stones
-
- Other _____

How is your sexual energy?

What kind of birth control do you use?

Do you have (check all that apply):

-
- Infertility
-
- Pain during sexual relations
-
- Other _____

Women

At what age did you start menstruating?

Number of days between cycles?

Number of days of flow?

Color?

I have or have had (check all that apply):

-
- Irregular menstruation
-
- Heavy flow
-
- Light flow
-
- No flow
-
- Clots
-
-
- Vaginal itching/burning
-
- Spotting between periods
-
- Discomfort/pain before period
-
-
- Discomfort/pain during period
-
- Other _____

Any vaginal discharge? Yes No

Amount

Color

Frequency

PMS Symptoms?

Number of pregnancies?

Number of deliveries?

Abortion(s)/Miscarriage(s)?

Menopausal Symptoms?

Men

I have (check all that apply):

-
- Prostatitis
-
- Impotence
-
- Penis blood/mucous discharge
-
- Other _____

Muscles, Joints & Bones	
Do you have pain or tightness? <input type="checkbox"/> Yes <input type="checkbox"/> No	Where?
The pain is (check all that apply):	<input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Numb <input type="checkbox"/> Deep pain <input type="checkbox"/> Burning <input type="checkbox"/> Dull <input type="checkbox"/> Superficial pain <input type="checkbox"/> Tingling <input type="checkbox"/> Pain worse/better with heat <input type="checkbox"/> Pain worse/better with cold <input type="checkbox"/> Pain worse/better with pressure <input type="checkbox"/> Pain worse/better in the am/pm
I have (check all that apply):	<input type="checkbox"/> Swollen joints <input type="checkbox"/> Arthritis/joint pain <input type="checkbox"/> Tendonitis <input type="checkbox"/> Rheumatism <input type="checkbox"/> Bone pain <input type="checkbox"/> Muscle cramping <input type="checkbox"/> Muscle pain <input type="checkbox"/> Repetitive strain injury <input type="checkbox"/> Other _____

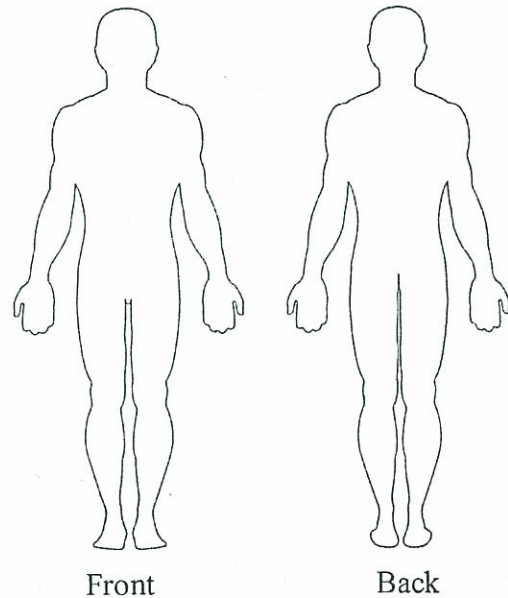
Respiratory, Eyes, Ears, Nose, Throat & Head	
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ per day for _____ years
I have (check all that apply):	<input type="checkbox"/> Frequent colds <input type="checkbox"/> Chronic runny nose <input type="checkbox"/> Chronic cough <input type="checkbox"/> Coughing blood
	<input type="checkbox"/> Pain inhaling <input type="checkbox"/> Shortness of breath on exertion/at rest <input type="checkbox"/> Asthma <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Pain/red eyes
	<input type="checkbox"/> Poor vision <input type="checkbox"/> See spots <input type="checkbox"/> Dizziness <input type="checkbox"/> Cold sores <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Dry mouth
	<input type="checkbox"/> Ear pain <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Clogged/popping ears
	<input type="checkbox"/> Frequent sore throat <input type="checkbox"/> Cough up mucous: How much? _____ Color of phlegm? _____
	<input type="checkbox"/> Frequent headaches/migraines: Describe: _____
<input type="checkbox"/> Other _____	

Cardiovascular	
Blood pressure _____ / _____	Have you ever been diagnosed with heart trouble? <input type="checkbox"/> Yes <input type="checkbox"/> No
I have (check all that apply):	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Varicose veins <input type="checkbox"/> Phlebitis <input type="checkbox"/> Cold hand and feet
	<input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Poor circulation <input type="checkbox"/> Other _____

Skin & Hair	
I have or often have (check all that apply):	<input type="checkbox"/> Dry skin <input type="checkbox"/> Skin rashes <input type="checkbox"/> Itching <input type="checkbox"/> Acne <input type="checkbox"/> Eczema <input type="checkbox"/> Hives
	<input type="checkbox"/> Hair loss <input type="checkbox"/> Premature graying <input type="checkbox"/> Other _____

Family Medical History (Please list any significant family illnesses)
Mother
Father
Siblings
Grandparents

On the following drawing, shade the areas you feel should be addressed:



CONSENT FORM

To All Clients:

While receiving acupuncture treatment, please feel free to communicate with your practitioner what you experience during the needling process, as this will enable them to adjust needles and the points selected to maximize your comfort during treatment. If you experience dizziness, nausea, a cold sweat, shortness of breath, or faintness during treatment, please let the practitioner know immediately. This is known as needle shock, and while its occurrence is extremely rare, it helps to let the practitioner know if you experience any of these symptoms so that the needles can be removed. These symptoms go away immediately after needles are withdrawn, and are generally caused by anxiety when receiving acupuncture for the first time. Other possible side effects of acupuncture treatment may include local bruising, mild pain in the area treated, brief generalized fatigue, tingling or numbness.

Other important things to keep in mind regarding acupuncture treatment:

- While the needles are in place, do not change your position or move suddenly.
- Wear comfortable, loose clothing. We provide a paper gown during treatment if you want one.
- Maintain good personal hygiene.
- Avoid treatment when excessively fatigued, hungry, full, or emotionally upset.
- We are unable to treat patients who are intoxicated and/or are abusing substances.

Everyone responds to treatment differently therefore, we cannot guarantee the outcome of treatment. Some individuals experience total or partial relief of their pain or symptoms after the first few treatments. Others notice steady, gradual improvement. In some cases, no relief is felt at all until after several days go by. Occasionally, some people notice that their pain actually seems to be worse before it gets better. Let us know how you responded to the previous treatment at the time of your follow-up visits, so that your treatment plan can be adjusted accordingly. Depending on your condition and your goals for treatment, we may require a physician referral.

Clients are advised to consult a physician regarding the condition or conditions for which they are seeking acupuncture treatment. In addition, clients are responsible for seeking the advice and treatment of a physician should their symptoms change for the worse, or should any new condition arise.

If you have any concerns regarding your treatment, please don't hesitate to speak to your practitioner.

I have read and understand the above statement
Signature of Patient

Date

Signature of Licensed Acupuncturist

Date