Initial Patient Assessment

245 Main Street
Suite 2M
Matawan, NJ 07747
732.242.4536

Name:_____ **Age**:_____ **DOB**: ___/____/_____

Chief Complaint:_____

Onset:_____ **Duration**: _____ **Frequency**:_____

Severity: (minimal) 1 2 3 4 5 6 7 8 9 10 (extreme)

Better when:_____

Worse when:_____

Diagnosed by an M.D.? Y N **Diagnosis**:_____

Been treated? Y N **Effective?** Y N **Treated by**:_____

Treatment:_____

Additional complaints:

_____

_____

_____

_____

Current Medications: _____

Allergies:_____

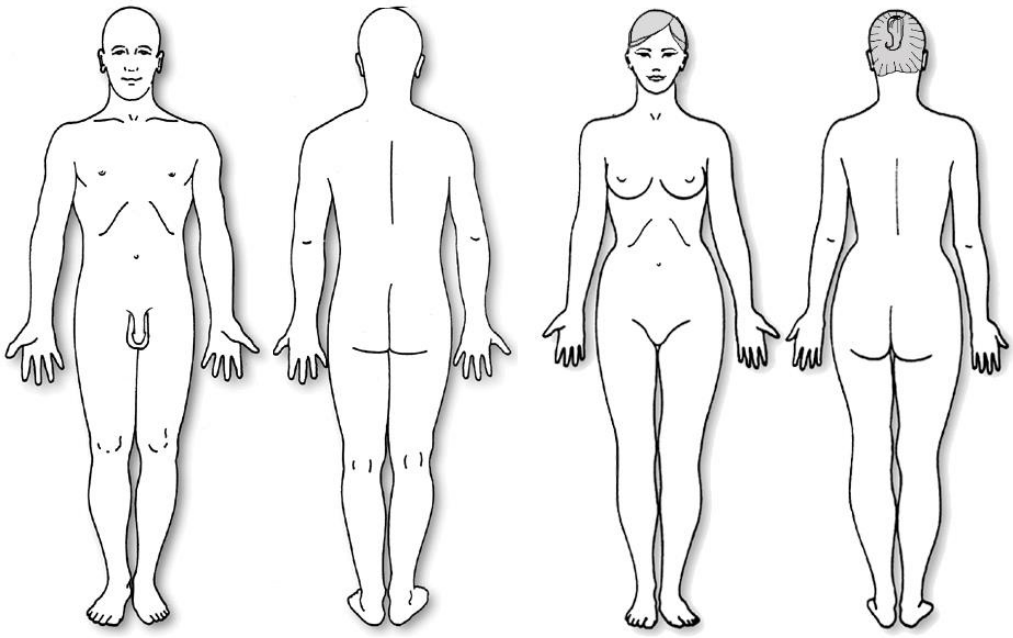
Past Medical History:

_____

_____

Current Patient Profile

Body Pain/Discomfort:



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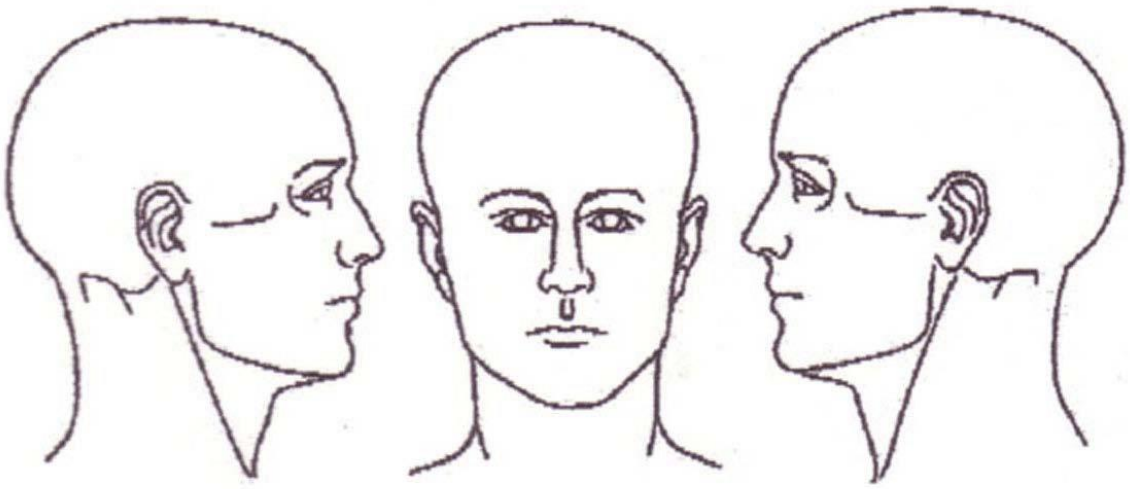
Please describe and be specific:

_____
_____
_____

Headaches/Face Discomfort:



Please describe and be specific:

_____
_____
_____

For the following sections, please put "A" for always, "S" for sometimes, and leave blank for never in the boxes preceding the symptom:

Temperature (KD)

- ☐ **Cold hands**
- ☐ **Cold feet**
- ☐ **Sweaty hands**
- ☐ **Sweaty feet**
- ☐ **Hot body**
- ☐ **Cold body**
- ☐ **Noon flushes**
- ☐ **Night sweats**
- ☐ **5 Palm Heat**
- ☐ **Day hot flash**
- ☐ **Thirst**
- ☐ **No Thirst**
- ☐ **Easily sweat**
- ☐ **No sweat**

Overall Energy (LU, KD)

- ☐ **Shortness of breath**
- ☐ **General Weakness**
- ☐ **Frequent Colds**
- ☐ **Low energy**
- ☐ **Worst after Exercise**
- ☐ **Fatigue**

Heart/Chest (HT)

- ☐ **Palpitations**
- ☐ **Anxiety**
- ☐ **Low BP**
- ☐ **High BP**
- ☐ **Chest tightness**
- ☐ **Chest Pain**
- ☐ **Insomnia**
- ☐ **Restlessness**

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Skin/Throat/Respiratory System (LU)

- ☐ **Nasal Discharge**
  - **White**
  - **Yellow**
  - **Thick**
  - **Thin**
- ☐ **Cough**
  - **Dry**
  - **With sputum**
- ☐ **Wheeze**
- ☐ **Nosebleed**
- ☐ **Dry nose**
- ☐ **Dry mouth**
- ☐ **Sinus Congestion**
- ☐ **Dry skin**
- ☐ **Dry/sore throat**
- ☐ **Acne**
- ☐ **Skin rash**
- ☐ **Stiff neck**
- ☐ **Stiff shoulders**
- ☐ **Difficulty breathing**
- ☐ **Sadness**
- ☐ **Depression**

Gastrointestinal (ST, SP, LI, SI)

- ☐ **Low appetite**
- ☐ **Ravenous appetite**
- ☐ **Weight gain**
- ☐ **Weight loss**
- ☐ **Bloating/Gas**
- ☐ **Nausea/Vomiting**
- ☐ **Borborygmus**
- ☐ **Easily bruised**
- ☐ **Hemorrhoids**
- ☐ **Loose stools**
- ☐ **Constipation**
- ☐ **Diarrhea**
- ☐ **Blood in stools**
- ☐ **Mucous in stools**
- ☐ **Undigested food**
- ☐ **Strong odor from stool**
- ☐ **Frequent BM**
- ☐ **Infrequent BM**
- ☐ **Bleeding gums**
- ☐ **Halitosis**
- ☐ **Acid reflux**
- ☐ **Stomach pains**
- ☐ **Stomach ulcers**
- ☐ **Pensiveness**
- ☐ **Constant Worry**
- ☐ **Constant Stress**

Dampness in Body (SP)

- ☐ **Heaviness sensation**
- ☐ **Mental heaviness**
- ☐ **Mental sluggishness**
- ☐ **Mental fogginess**
- ☐ **General edema**
- ☐ **Swollen hands**
- ☐ **Swollen feet**
- ☐ **Swollen joints**
- ☐ **Chest congestion**
- ☐ **Nasal discharge**
- ☐ **Sweating**

Eyes (LV)

- ☐ **Itchy**
- ☐ **Bloodshot**
- ☐ **Hot**
- ☐ **Dry**
- ☐ **Watery**
- ☐ **Gritty**
- ☐ **Blurry vision**
- ☐ **Nighttime blindness**
- ☐ **Nearsighted/Farsighted**

Urinary (KD, BL)

- ☐ **Frequent urination**
- ☐ **Infrequent urination**
- ☐ **Strong odor**
- ☐ **Burning/painful urination**
- ☐ **Incontinence**
- ☐ **Kidney Stones**
- ☐ **Bladder Stones**
- ☐ **Bedwetting**
- ☐ **Abnormal color urine**
  - **Dark yellow**
  - **Reddish**
  - **Cloudy**

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Other (LV, GB)

- ☐ **Hypochondric pain**
- ☐ **Pain in flanks**
- ☐ **Hypocondric distension**
- ☐ **Muscle spasms/cramping**
- ☐ **Tingling sensation**
- ☐ **Numbness**
- ☐ **Seizures/Tremors**
- ☐ **Tinnitus**
- ☐ **Easily angered**
- ☐ **Easily frustrated**
- ☐ **Irritability**
- ☐ **Bitter taste in mouth**

Other (KD)

- ☐ **Weak Knees**
- ☐ **Pain in Knees**
- ☐ **Weak Lower Back**
- ☐ **Pain in Lower Back**
- ☐ **Joint Pain**
- ☐ **Teeth Pain**

Additional Symptoms/Concerns:

_____

_____

_____

Women Only:

- ☐ **Irregular Cycle**
- ☐ **Heavy Periods**
- ☐ **Light Periods**
- ☐ **Clots**
- ☐ **PMS symptoms**
- ☐ **Spotting**
- ☐ **Cramps**
- ☐ **Vaginal discharge**
- ☐ **Menopausal symptoms**
- ☐ **Infertility**
- ☐ **Breast lumps**
- ☐ **Breast tenderness**

Age of first Menses: _____ **# Days of Menses: _____** **Length of Cycle: _____**

Age of Menopause: _____ **Currently Pregnant? Y N** **Birth Control? Y N**

 # Pregnancies: _____ # Miscarriages:_____ # Live Births: _____ # Abortions: _____

Other concerns regarding reproductive system:

_____

_____

Men Only:

- ☐ **Nocturnal Emissions**
- ☐ **Penile Discharge**
- ☐ **Testicular Pain/Swelling**
- ☐ **Prostate Problems**
- ☐ **Impotence**
- ☐ **Premature Ejaculation**

Other concerns regarding reproductive system:

_____

_____

I hereby declare that I have filled out this intake form honestly and to the best of my ability, and will update my acupuncturist if there are any changes as my treatment continues.

Signed: _____ Date:_____