

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:

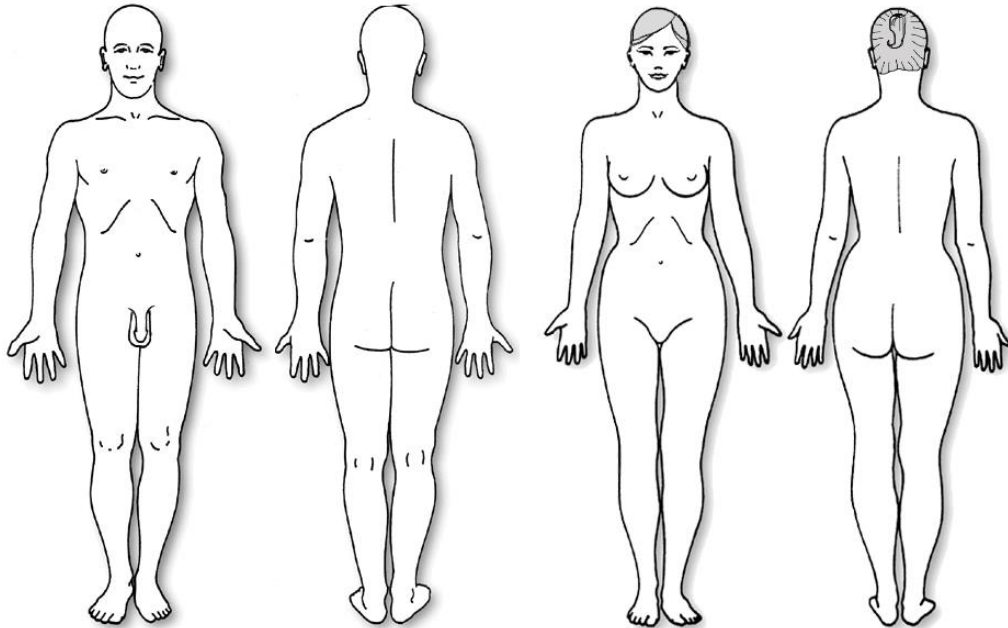
Current Medications: _____

Allergies: _____

Past Medical History:

Current Patient Profile

Body Pain/Discomfort:

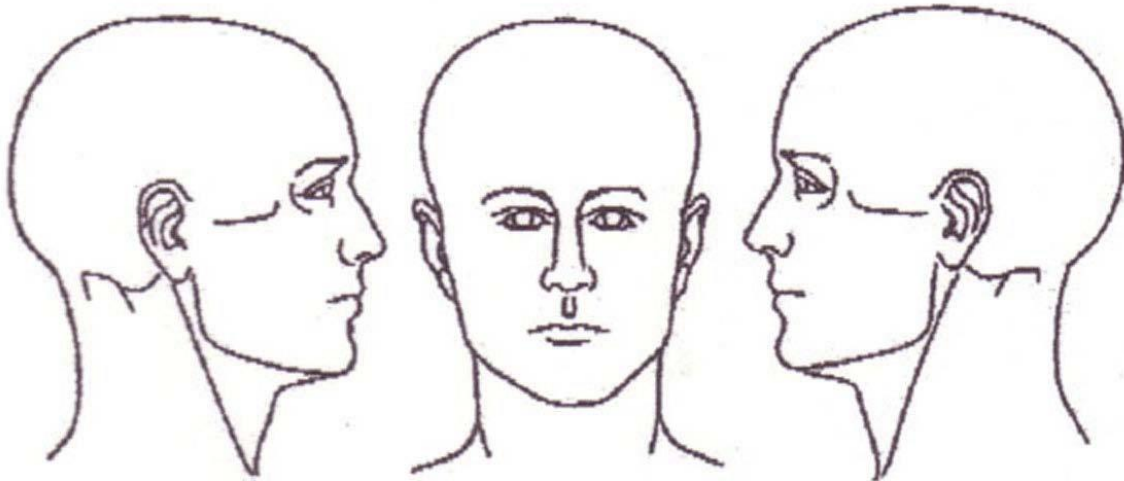


Initial Patient Assessment

245 Main Street
Suite 2M
Matawan, NJ 07747
732.242.4536

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)

- | | | | |
|---------------------------------------|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Hot body | <input type="checkbox"/> 5 Palm Heat | <input type="checkbox"/> Easily sweat |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold body | <input type="checkbox"/> Day hot flash | <input type="checkbox"/> No sweat |
| <input type="checkbox"/> Sweaty hands | <input type="checkbox"/> Noon flushes | <input type="checkbox"/> Thirst | |
| <input type="checkbox"/> Sweaty feet | <input type="checkbox"/> Night sweats | <input type="checkbox"/> No Thirst | |

Overall Energy (LU, KD)

- | | | |
|--|---|---|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Worst after Exercise |
| <input type="checkbox"/> General Weakness | <input type="checkbox"/> Low energy | <input type="checkbox"/> Fatigue |

Heart/Chest (HT)

- | | | | |
|---------------------------------------|----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Low BP | <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> High BP | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Restlessness |

Initial Patient Assessment

245 Main Street
Suite 2M
Matawan, NJ 07747
732.242.4536

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

Initial Patient Assessment

245 Main Street
Suite 2M
Matawan, NJ 07747
732.242.4536

Other (LV, GB)

- | | | |
|---|---|--|
| <input type="checkbox"/> Hypochondric pain | <input type="checkbox"/> Tingling sensation | <input type="checkbox"/> Easily angered |
| <input type="checkbox"/> Pain in flanks | <input type="checkbox"/> Numbness | <input type="checkbox"/> Easily frustrated |
| <input type="checkbox"/> Hypocondric distension | <input type="checkbox"/> Seizures/Tremors | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Muscle spasms/cramping | <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Bitter taste in mouth |

Other (KD)

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Weak Knees | <input type="checkbox"/> Weak Lower Back | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Pain in Knees | <input type="checkbox"/> Pain in Lower Back | <input type="checkbox"/> Teeth Pain |

Additional Symptoms/Concerns:

Women Only:

- | | | |
|--|--|--|
| <input type="checkbox"/> Irregular Cycle | <input type="checkbox"/> PMS symptoms | <input type="checkbox"/> Menopausal symptoms |
| <input type="checkbox"/> Heavy Periods | <input type="checkbox"/> Spotting | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Light Periods | <input type="checkbox"/> Cramps | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Clots | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> 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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Nocturnal Emissions | <input type="checkbox"/> Testicular Pain/Swelling | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Penile Discharge | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> 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: _____