Victoria Allen Acupuncture
Patient Evaluation Form
www.victoriaallenacupuncture.com

Information provided on this form is confidential.

Today's Date: ____/____/____

Name: ________________________ DOB: ____/____/____ Gender: Male__ Female__

Street Address: _______________________________________ City: ____________________

State: _____________________________ Zip: ___________________

Occupation: ____

Primary Care Physician: ____

His/Her phone number:_________________Date of last complete medical exam ____________

You were referred by: ____

Contact Information

Mobile Phone: ___________________________ Home Phone: _________________________

Email: __________________________ Preferred method of reminders: Phone call, email, text

Emergency Contact: _______________________ Relationship: ___________________________

Home/Cell Phone: ____

What would you like treated by acupuncture? ____

How long have you had this condition? ________________The onset was: _ Sudden _ Gradual

What medical diagnosis, if any, have you received? _____________________________________

Symptoms are worsened by ____________________ Better with ________________________

What other treatments have you received for this or other conditions? (Chiropractic, physical therapy, massage, etc..) ____

In general, do you feel hot or cold? _____________ Do you have chills or fever? ______________

Please list any medications, herbs, or supplements you are currently taking, whether prescription or nonprescription:

Names of Medications/Supplements	For What Condition(s)?

Are you currently pregnant? _ Yes _.No

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

List any serious injuries, illnesses or surgeries you have had.

_______ Age ____

_______ Age ____

_______ Age ____

_______ Age ____

_______ Age ____

FAMILY HISTORY: Place an X in the box indicating any illnesses your family members have ever had.

	FATHER	MOTHER	SIBLINGS	GRANDPARENTS	CHILDREN
Allergies					
Blood disorders					
Diabetes					
Cancer or Tumors					
Neurological Disorders					

	FATHER	MOTHER	SIBLINGS	GRANDPARENTS	CHILDREN
High Blood Pressure					
Heart Disease (Stroke)					
Psychological Disorders					
Drug Abuse					
Orthopedic Disorders					
Other					

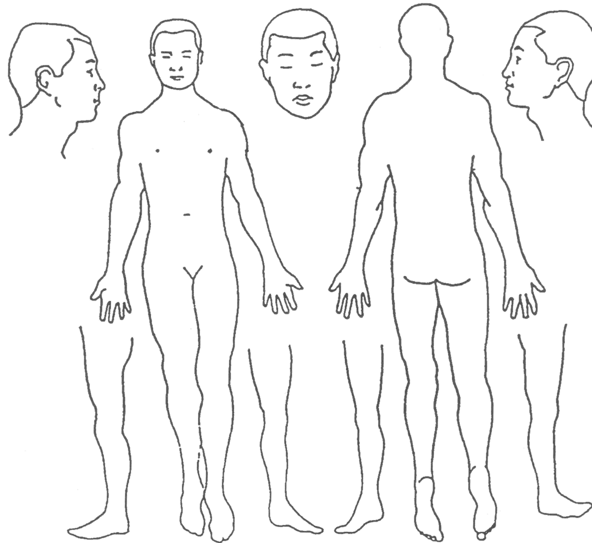
Please check any conditions you currently have or have had in the last year. Circle any conditions you have had in the past.

_ Aids/HIV
_ Alcoholism
_ Diabetes
_ Allergies
_ Heart Disease
_ Anemia
_ Hepatitis A, B, or C
_ Arthritis
_ Herpes

_ Asthma - Difficulty _Inhaling _Exhaling
_ Lyme Disease
_ Bleeding Disorders
_ Multiple Sclerosis
_ Cancer/Tumors
_ Seizures
_ Tuberculosis
_ Other ______

Do you have a pacemaker? _ Yes _ No

Please shade in any areas you feel need to be addressed.



Please answer questions and check any symptoms you have or have had in the last year.

Diet, Lifestyle and Emotions

How is your appetite? _ Good _ Poor _ No Appetite _ Always Hungry

What do you typically eat for:

Breakfast ___________________________________

Lunch ___________________________________

Dinner ___________________________________

Snacks ___________________________________

Describe any food cravings you have: ___________________________________

How often do you have sugar/sweets? ___________________________________

How often do you have coffee/tea? ___________________________________

How much water do you drink daily? ___________________________________

Are you: _ Always Thirsty _ Never Thirsty _ Thirsty but have no desire to drink

You prefer _ Hot Drinks _ Cold Drinks _ Drinks that are room temperature

How much alcohol do you consume on a weekly basis? ___________________________________

Please rate your energy on a scale of 1 to 10: ___________________________________

At what time of the day is your energy highest? ________________ lowest?________________

What is your current exercise regime? ___________________________________

Does exercise _invigorate you? _make you more tired?

Are you experiencing any of the following (check all that apply)?

_Depression

_ Anxiety

_ Panic Attacks

_Nervousness

_Irritability

_Difficult Concentration

_Poor Memory

_ Other: ___________________________________

Diet, Lifestyle and Emotions (continued)

Describe how stress affects you. ____

Where do you hold stress? ____

What do you do to relax? ____

How many hours do you usually sleep per night? ____________

Any _night sweats? _disturbing dreams/nightmares?

Do you have trouble _falling asleep? or _staying asleep?

Musculoskeletal

Do you have:

_Pain

_ Numbness

_ Tightness/Lack of mobility

_Tremors

_Swelling

_ Cramping

Where? _ Arms _ Legs _ Neck _ Back _ Hands _ Feet _ Shoulders _ Hips

Is the pain: _ Better or _ Worse with heat? _ Better or _ Worse with cold?

_ Better or _ Worse with pressure?

_ Other: ____

Eyes/Ears/Nose/Throat/Respiratory

_Blurred or failing vision

_Floaters

_Eye pain

_Dry and/or itchy eyes

_Red eyes

_Frequent sore throat

_Hearing loss

_Ringing in ears

_Clogged/Pressure in ears

_Earache

_Dizziness

_Frequent colds

_ Chronic cough

_ Cough up mucous

_Difficulty breathing

_Sinus problems

_Nosebleeds

_Bleeding gums

_ Other: ____

Skin and Hair

_Dry Skin
_Itching
_Skin Rash
_Eczema
_Psoriasis
_Acne
_Easily Bruise
_Hair Loss
_Premature Graying
_ Other:______________________________

Cardiovascular

_Chest Pain
_Rapid Heartbeat
_Irregular Heartbeat
_High/Low Blood Pressure
_Poor Circulation
_ Other: ____________________________

Gastrointestinal

_Belching
_ Gas
_Bloating
_Acid reflux
_Nausea
_Loose Stool
_Dry /Hard Stool
_Indigestion
_Constipation
_Diarrhea
_Vomiting
_Stomach Pain
_Undigested Food in
_Stool
_Painful Bowel
_Movements
_Hemorrhoids

_ Other: ____

Genito/Urinary

What color is your urine? _Clear _Pale Yellow _Dark Yellow/Orange

Do you have :

_Frequent Urination
_Incontinence
_Blood/Pus In Urine
_Urinary Tract Infections
_Kidney Stones
_Lowered Libido

_Other: ____

Women

What is the number of days between your cycles?______ Average number of days of flow?_______

The color is: _Brownish/Black _Bright Red _Light Red

The flow is: _Heavy _Moderate _Light

Do you have:

_Irregular Cycle	_Dysmenorrhea (Painful Menses)	_Vaginal Discharge
_Blood Clots	_Bleeding Between Periods	_Vaginal Itching/Burning
_Amenorrhea (Lack of Menses)		_Uterine Fibroids
		_Menopausal Symptoms

_Other: ____

How many pregnancies have you had? ______ Any previous miscarriages? _Yes _ No

Men

_Prostatitis	_Premature Ejaculation	_Penis Discharge
_Erectile Dysfunction	_Seminal Emission	_Genital Pain

_Other: ____

Facial Rejuvenation (if applicable)

Please describe what features of your face you would like to address:

____

Thank You!