Golden Needle Acupuncture and Wellness, LLC.

Acupuncture – Evaluation Form

Information provided on this form is confidential.

PLEASE PRINT

Date ___/___/_____

Name _____ Age _____ Sex ☐ Male ☐ Female

Address _____ Occupation _____

City State _____ ZipCode _____ Date of Birth ___/___/_____

Telephone Day ( ) _____ Extension _____ Evening ( ) _____

Referred by _____

Physician _____ Telephone ( ) _____

What do you want treated with acupuncture? _____

How long have you had this condition? _____ The onset was ☐ Sudden ☐ 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.

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

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: Breakfast _____

Lunch _____ Dinner _____

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 ☐ No Do you prefer ☐ Hot OR ☐ Cold drinks?

Do you have unusual sweating? When? _____ Other? _____

How many glasses/ cups do you 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 Movement? ☐ 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 per 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? Where? _____

The pain is (Check ALL that apply) ☐ Sharp ☐ Aching ☐ Numb ☐ Deep pain ☐ Burning ☐ Dull

☐ Superficial pain ☐ Tingling ☐ Pain Worse/ Better with heat ☐ Pain Worse/ Better with cold

☐ Pain Worse/ Better with pressure ☐ Pain Worse AM/ PM

I have (Check ALL that apply) ☐ Swollen joints ☐ Arthritis/ joint pain ☐ Tendonitis ☐ Rheumatism

☐ Bone pain ☐ Muscle cramping ☐ Muscle pain ☐ Repetitive strain injury

☐ Other _____

Respiratory, Eyes, Ears, Nose, Throat & Head

Do you smoke? ☐ Yes ☐ No _____ per day, for _____ years

I have (Check ALL that apply) ☐ Frequent colds ☐ Chronic runny nose ☐ Chronic cough ☐ Coughing blood

☐ Pain Inhaling ☐ Shortness of breath on exertion/ at rest ☐ Asthma ☐ Nose bleeds ☐ Pain/ red eyes

☐ Poor vision ☐ See spots ☐ Dizziness ☐ Cold sores ☐ Bleeding gums ☐ Dry mouth ☐ Frequent sore throat

☐ Ear pain ☐ Ringing in ears ☐ Clogged/ popping ears

☐ Frequent sore throat ☐ Cough up mucous How much? _____ Color of phlegm? _____

☐ Frequent headaches/ migraines Describe _____

_____

☐ Other _____

Cardiovascular

Blood Pressure ____/____ Have you ever been diagnosed with heart trouble? ☐ Yes ☐ No

I have (Check ALL that apply) ☐ Chest pain ☐ Palpitations ☐ Varicose veins ☐ Phlebitis ☐ Cold hands & feet

☐ Irregular heart beat ☐ Poor circulation ☐ Other _____

Skin & Hair

I have or often have (Check ALL that apply) ☐ Dry skin ☐ Skin rashes ☐ Itching ☐ Acne ☐ Eczema ☐ Hives

☐ Hair loss ☐ Premature graying ☐ Other _____

Family Medical History (Please list any significant family illnesses)

Mother _____

Father _____

Siblings _____

Grandparents _____

On the following drawing, SHADE in the areas that you feel should be addressed.