Acu-Care, LLC 243 Bridge St, Metuchen, NJ 08840 **609-240-8338**

Patient Evaluation Form - Information provided on this form is confidential

PLEASE PRINT Date: ____/____/_____

Name _____ Age _____ Height: _____ Weight: _____

Address _____ Occupation: _____

City/State _____ ZipCode Date of Birth: ____/____/_____

Telephone Day: _____ Cell: _____

Email: _____ Text: ☐ yes ☐ no

Sex: ☐ Male ☐ Female Marital Status: ☐ married/stable relationship ☐ single ☐ divorced ☐ widowed

Referred by: _____

Physician: _____ Telephone: _____

Emergency Contact: _____ Telephone: _____

What is your primary complaint? _____

How long have you had this condition: _____

Was the onset: ☐ sudden ☐ gradual What makes it better: _____ What makes it worse: _____

On a scale of 0 to 10 (0 = no pain, and 10 = worst pain), how would you rate the pain?: _____

On a scale of 0 to 10 (0 = no discomfort, and 10 = worst discomfort), how would you rate the discomfort?: _____

Do you have a MD diagnosis? _____

_____

What are your secondary complaints (include onset & duration)**?** _____

_____

_____

_____

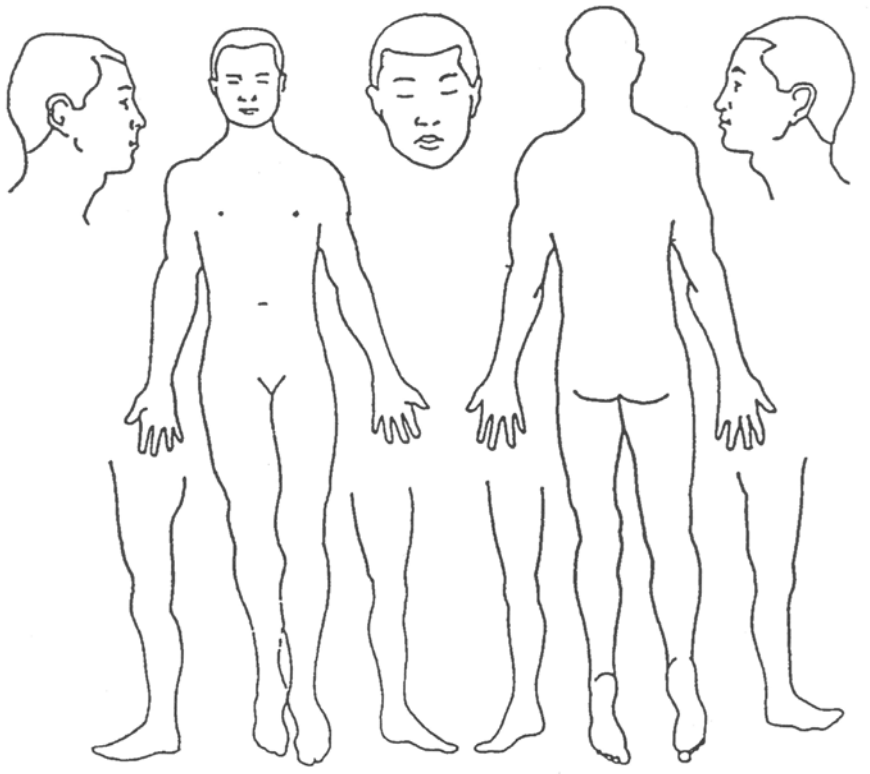
Other Treatments (What other treatments have you received recently for this and/or other conditions?) _____

_____

_____

PRACTITIONER NOTES:

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



MUSCULOSKELETAL

neck pain - upper back pain - lower back pain - foot/ankle pain - hip pain - shoulder pain - elbow pain
arm/hand pain - carpal tunnel - sciatica - scoliosis - arthritis/joint pain - tendonitis - bone pain

TMJ dysfunction - muscle cramping - muscle weakness - pain worse am/pm - pain when sleeping

pain worse/better with heat pain worse/better with cold - pain worse/better with pressure

quality of pain: sharp - aching - numb - mild - deep - superficial - burning - dull - tingling

Medical History

In gray-shaded areas - CIRCLE all that apply

In areas NOT gray-shaded, provide information if it applies

CARDIOVASCULAR – ever diagnosed with heart trouble? ☐ Yes ☐ No - blood pressure _____/_____

pacemaker - irregular heartbeat - chest pain - shortness of breath - cold hands/feet - raynaud's

EMOTIONS – how do you feel emotionally? _____

where do you hold stress? _____ how do you relax? _____

panic attacks - depression - anxiety - angry - bad temper - irritable - nervous - stress

ENDOCRINE SYSTEM

hypothyroid - hyperthyroid - diabetes – goiter - Cushing's - Addison's

Medical History - continued

EYES, EARS, NOSE & THROAT

painful/red eyes - poor/blurred vision - eye pain - dry eyes - hearing loss - tinnitus (ringing in ears)
ear pain - headaches - sinus congestion/infection - dry throat - difficulty swallowing

GASTRONINTESTINAL – bowel movements: how often? _____ day/week How is your appetite? _____

bowel movements: painful - constipation - diarrhea - use laxatives - loose stool - hard stool
nausea - heartburn/GERD - IBS/IBD - belching - bloating - bad breath - abdominal pain - cramps

IMMUNE SYSTEM –

thyroid disease/dysfunction - HIV/AIDS - fatigue - food allergy - seasonal allergies - latex allergies

allergies: _____

food intolerances: _____

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

frequent colds - chronic runny nose - chronic cough - coughing blood - pneumonia - asthma
bronchitis - pain/difficulty inhaling - pain/difficulty exhaling - shortness of breath on exertion
shortness of breath at rest - emphysema - tuberculosis

SKIN & HAIR – psoriasis - eczema - hives - skin rashes – acne - dry skin - itching

never or rarely sweat – excess sweating - red face – face easily flushes - hair loss - shingles

URINARY & GENITAL

Urination: how often? __ times per day color: ☐ clear ☐ pale yellow ☐ yellow ☐ dark yellow/orange

trouble starting stream - frequent urination - incontinence - painful or burning urination
dribbling when sneezing - urinary tract infections - blood in urine - waking at night to urinate - kidney stones
infertility - pain during sexual relations - genital pain MEN ONLY: prostatitis - impotence

WOMEN – when was your last period? _____ number of days between cycles? _____
number of days of flow _____ color _____

are you **currently** pregnant? ☐ Yes ☐ No Please let us know if you become pregnant in the future.

menopause symptoms: _____

discomfort/pain before period - discomfort/pain during period - heavy flow - light flow - clotting - cramps
PMS - fibroids - endometriosis - ovarian cysts - breast implants - vaginal discharge

MISCELLANEOUS –

In general, do you feel hot or cold? _____ Do you ever have a bitter taste in your mouth? ☐ Yes ☐ No

hepatitis - sexually transmitted diseases - anemia - lyme disease - migraines - weight gain/loss - bruise or bleed easily

how many hours do you normally sleep? ___

do you have difficulty with?: falling asleep - staying asleep - disturbed sleep

do you wake up during the night around the same time? ____ am/pm do you have night sweats? ☐ Yes ☐ No

Other Conditions: _____

_____

ENERGY & EXERCISE – on a scale of 1 to 10 (1 = lowest, 10 = highest), rate your overall energy level? _____

what time of day is your energy: highest? _____ lowest? _____ do you fatigue easily? ☐ Yes ☐ No

what kind of exercise do you do? _____ how often? _____

List any vitamins and supplements you are taking _____

_____

_____

_____

Medications & Drugs

Check all that apply: ☐ birth control pills ☐ alcohol ☐ recreational drugs

Prescription Drugs (include reason for prescription next to each drug) _____

_____

_____

_____

Family Medical History **(Please list any significant family illnesses)**

Mother _____

Father _____

Siblings _____

Grandparents _____

SIGNATURE: _____ DATE: _____
(SIGNATURE OF PARENT, IF UNDER 18)

PRACTITIONER NOTES: