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The Lutherville Wellness Garden

INITIAL EVALUATION FORM

Patient's Name _____ **Date** _____
Address _____ **Phone** _____
City _____ **State** _____ **Zip** _____ **Cell** _____
Gender ____ **Age** ____ **Weight** ____ **Height** ____ **Date of Birth** _____
Email Address _____ (for email reminders)
Insurance Co _____ **Is this workman's comp/auto related?** ____
Policy Holder _____ **Policy Holder DOB** _____
Relation to you _____ (if different home address, please note on side)
Emergency Contact _____ **Phone** _____
Family Physician _____ **Phone** _____
Specialist (if relevant) _____ **Phone** _____
How did you hear about us? _____
Have you ever had acupuncture before? _____

Current Medical History

Primary Reason for Visit _____

Other concerns you would like to address _____

How long have you had your problem? _____
Has a physician given you a diagnosis? _____
Have you had MRI, X-ray, lab tests for this condition? _____
(if you have had any of the above, please bring the written report to your initial visit, if possible, to assist in a complete evaluation. If there are metal implants, fusions, screws, etc. please bring the actual films)
What was the initial cause? _____
Is it getting worse? ____ **How so?** _____
What makes your condition better? _____
What makes it worse? _____
Is it worse at certain times of year? _____ **Certain weather?** _____
What treatments are you currently using? _____
Are they effective? _____
What treatments have you tried in the past? _____
Were they effective? _____
Current Medications/Supplements _____

Past Medical History

Surgeries/Medical Procedures (include dates) _____

Past Physical Traumas (e.g. car accident, fall, childhood injuries) _____

Past Emotional Traumas (e.g. divorce, death in family, childhood trauma) _____

Past Medications (e.g. Chemotherapy, Steroids, Childhood antibiotics) _____

Check any of the following conditions you have currently or have had in the past

- | | | |
|-----------------------|---------------------------|----------------------|
| ___ Auto-immune | ___ Depression | ___ Mumps |
| ___ Appendicitis | ___ Emphysema | ___ Nervous disorder |
| ___ Alcoholism | ___ Gall bladder disorder | ___ Osteoporosis |
| ___ Allergies | ___ Glaucoma | ___ Pacemaker |
| ___ Antibiotic use | ___ Gout | ___ Parasites |
| ___ Appendicitis | ___ Heart disease | ___ Phlebitis |
| ___ Arthritis | ___ Headaches | ___ Pneumonia |
| ___ Asthma | ___ Hepatitis | ___ Seizures |
| ___ Birth trauma | ___ Herpes | ___ STD's |
| ___ Bleeding disorder | ___ Hypertension | ___ Stroke |
| ___ Blood clots | ___ IBS | ___ Thyroid disorder |
| ___ Bronchitis | ___ Jaundice | ___ Tuberculosis |
| ___ Chicken pox | ___ Kidney disorder | ___ Vascular disease |
| ___ Cancer (specify) | ___ Liver disorder | ___ Ulcers |
| _____ | ___ Measles | ___ Other (Specify) |
| _____ | ___ Mononucleosis | _____ |
| ___ Diabetes | ___ Multiple Sclerosis | _____ |

Family Medical History

Father: Alive/Age _____ Deceased/Age _____

Father health issues _____

Mother: Alive/Age _____ Deceased/Age _____

Mother health issues _____

Your birth order (e.g. 3rd child of 5) _____

Siblings (total #/health issues) _____

Other relevant family information _____

Lifestyle

Occupation _____ Hours per week _____ Stress level _____
Physical or other stressors from occupation _____

Married/partnered _____ Single _____

Hobbies/activities _____

Exercise (*what type, how often*) _____

After exercise, do you feel: Better _____ Worse _____ About the same _____

Energy level in general (*1-10*) _____ Time of day more energy _____ Time of day less _____

How much sleep on average _____ Night owl _____ Morning person _____

Alcohol frequency _____

Tobacco frequency _____

Caffeine frequency _____

Recreational drugs frequency _____

Social support (*family, friends, social organizations*) _____

Nutrition

Your appetite: Good _____ Fair _____ Poor _____ Fluctuates _____ Hungry w/no app _____

Do you eat: 3 meals/day _____ More frequent small meals _____ irregular meals _____

Do you eat breakfast? _____ Are you a vegetarian? _____ Times/week you eat out _____

What do you eat on a typical day?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Cravings

Sweet _____

Chocolate _____

Pasta _____

Salty _____

Cheese _____

Other (*specify*) _____

Sour _____

Bread _____

Please provide any additional information about your diet that you feel is relevant
(*foods you feel are best for you, foods you have adverse reactions/allergies/sensitivities to, foods you dislike, etc.*) _____

Psychological/Emotional

Circle the number that best applies to you:

	<i>Rarely</i>		<i>Neutral</i>		<i>Often</i>
Wood/Liver					
Depressed	1	2	3	4	5
Angry	1	2	3	4	5
Easily irritable	1	2	3	4	5
Lack of courage	1	2	3	4	5
Indecisive	1	2	3	4	5
 Fire/Heart					
Laughs easily	1	2	3	4	5
Anxious, restless	1	2	3	4	5
Easily frightened	1	2	3	4	5
 Earth/Spleen					
Happy, content	1	2	3	4	5
Compulsive caretaker	1	2	3	4	5
Worry, overthinking	1	2	3	4	5
Obsessive	1	2	3	4	5
 Metal/Lung					
Melancholy, sad	1	2	3	4	5
Grief	1	2	3	4	5
 Water/Kidney					
Fearful	1	2	3	4	5
Introverted	1	2	3	4	5
Lack of will	1	2	3	4	5

Please check any of the following conditions that you have or have had in the past:

General

General Body Temperature: ___ Cold ___ Cool ___ Temperate ___ Warm ___ Hot

Qi

- ___ Tired, fatigued
- ___ Tired after exercising
- ___ Spontaneous sweating
- ___ Wake up tired

Yang

- ___ Extreme fatigue
- ___ Chilled easily
- ___ Cold sweats

Qi

- ___ Palpitation
- ___ Shortness of breath upon exertion

Heart

Yang

- ___ Cold limbs
- ___ Blue lips

Lung

- ___ Feeble cough
- ___ Shortness of breath with exertion
- ___ Catch colds easily
- ___ Aversion to wind
- ___ Spontaneous sweating

(Yin?)

- ___ Dry cough
- ___ Dry mouth and throat
- ___ Afternoon fever
- ___ Night sweating

Spleen

- ___ General fatigue
- ___ Bloating after eating
- ___ Tired after eating
- ___ Loose stools/diarrhea
- ___ Weakness in limbs
- ___ Poor appetite
- ___ Bleed/bruise easily
- ___ Heavy menstrual bleeding
- ___ Prolapsed organs
- ___ Hemorrhoids

- ___ Prefer warm food
- ___ Abdom pain better with pressure and warmth
- ___ Diarrhea
- ___ Chilly with cold limbs
- ___ Loose stool with undigested food

Kidney

- ___ Low back pain
- ___ Knee pain
- ___ Frequent urination
- ___ Bone fractures, weakness
- ___ Dental problems
- ___ Difficulty inhaling a deep breath
- ___ Rapid and weak breathing
- ___ Asthma

- ___ Frequent urination at night
- ___ Clear urine
- ___ Swollen ankles, legs
- ___ Impotence
- ___ Loose stool w/ undigested food
- ___ Diarrhea in early morning

Liver

Qi

- ___ Mental depression
- ___ Irritability
- ___ Sighing
- ___ Flank pain and pain below ribs
- ___ Foreign body sensation in throat
- ___ Dysmenorrhea
- ___ Breast distension

Fire

- ___ Pain in head
- ___ Eye redness, swelling, pain
- ___ Bitter taste in mouth
- ___ Irritable

Liver (con't)

- Yang rising**
___ Headache
___ Dizziness

- Wind**
___ Itching
___ Pain that moves to various parts

Liver and Gallbladder (Damp-heat)

- ___ Scanty yellow urine
___ Bitter taste in mouth w/
poor appetite and nausea

- ___ Yellow whites of eyes and skin
___ Swelling, burning in genitals

- Yin**
___ Feel warm in afternoon
___ Feel warm in evening
___ Hot flashes
___ Deep heat in body
___ Low grade fever in PM
___ Night sweats
___ Heat in palm of hands
___ Heat in soles of feet
___ Flushed face
___ Thirsty for cold drinks

General

- Blood**
___ Dizziness/vertigo
___ Dry skin, hair, nails
___ Numbness/tingling in hands
or feet
___ Blurred or weak vision
___ Insufficient lactation
___ Scanty or infrequent period

Heart

- ___ Difficulty staying asleep
___ Mental restlessness
___ Anxiety esp that builds later in day

- ___ Difficulty falling asleep
___ Poor memory
___ Confusion

Lung

- ___ Dry cough
___ Dry throat
___ Cough w/blood

- ___ Rashes or hives
___ Itchy skin

Liver

- ___ Dry eyes
___ Heat in palms/soles of feet

- ___ Blurry vision
___ Numbness of limbs
___ Muscle twitches
___ Spasms of tendons
___ Dry brittle nails
___ Poor night vision
___ Floaters/spots in vision
___ Tremor, shaking

Kidney

Yin

- ___ Insomnia
- ___ Tinnitus
- ___ Dizziness
- ___ Poor memory
- ___ Low back/knee pain
- ___ Night sweats/hot flashes

Dampness/Phlegm

- ___ Foggy/sluggish thinking
- ___ Headaches like a band around the head
- ___ Ear discharge
- ___ Cysts
- ___ Difficulty getting up in morning
- ___ Sweaty hands/feet
- ___ Nodules
- ___ Acne

Lung

- ___ Sinus discharge
- ___ Chest congestion
- ___ Productive cough
- ___ Shortness of breath or wheezing
- ___ Post-nasal drip
- ___ Sinus infections
- ___ Difficulty breathing lying down

Spleen

- ___ Nausea
- ___ Weight gain
- ___ Aversion to greasy food
- ___ Cysts
- ___ Yellow sweating (stains)
- ___ Fungal infections

Kidney

- ___ Swollen feet/ankles/legs
- ___ Swollen joints

Gastro-Intestinal

- ___ Acid reflux
- ___ Nausea
- ___ Belching
- ___ Flatulence
- ___ Stomach/abdominal pain
- ___ Flank pain
- ___ Frequency of bowel movements per day (or per week if less) ___
- ___ Loose stool
- ___ Blood in stool
- ___ Incomplete bowel movements

Genito-Urinary

How many times do you normally urinate per day? _____
What color is your urine normally (without taking vitamins)? _____

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Discharge |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Strong-smelling urine | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Cloudy urine | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Dribbling after urination | <input type="checkbox"/> Kidney stones | |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Dribbling while coughing or jumping | |

Genito-Urinary Male

- | | | |
|---|--|---|
| <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Genital pain | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Low sperm count | <input type="checkbox"/> Swollen testicles | <input type="checkbox"/> Erectile dysfunction |
| <input type="checkbox"/> Discharges | <input type="checkbox"/> Cold, numb genitals | <input type="checkbox"/> Sex drive (1-10) |
| <input type="checkbox"/> Other (describe) _____ | | |

Genito-Urinary Female

- | | | |
|--|---|--|
| <input type="checkbox"/> Age menses began | <input type="checkbox"/> Number of pregnancies | <input type="checkbox"/> Birth control (specify type and how long) |
| <input type="checkbox"/> Age menopause | <input type="checkbox"/> Number of abortions | _____ |
| <input type="checkbox"/> Number of days in cycle | <input type="checkbox"/> Number of miscarriages | |
| <input type="checkbox"/> Number of days for period | <input type="checkbox"/> Pregnant currently? | |
| <input type="checkbox"/> Infertile | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Pain during intercourse |
| <input type="checkbox"/> Cysts | <input type="checkbox"/> Yeast infections | <input type="checkbox"/> Sex drive (1-10) |

Menstrual Cycle

- | | |
|--|--|
| <input type="checkbox"/> Irregular (specify) _____ | |
| <input type="checkbox"/> Spotting | <input type="checkbox"/> Cramping, pain |
| <input type="checkbox"/> PMS | <input type="checkbox"/> Clots, dark blood |
| <input type="checkbox"/> Headaches before period | <input type="checkbox"/> Mid-cycle bleeding |
| <input type="checkbox"/> Headaches after period | <input type="checkbox"/> Water retention, bloating |

Peri-menopausal symptoms

- | | | |
|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Spotting | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Vaginal dryness |

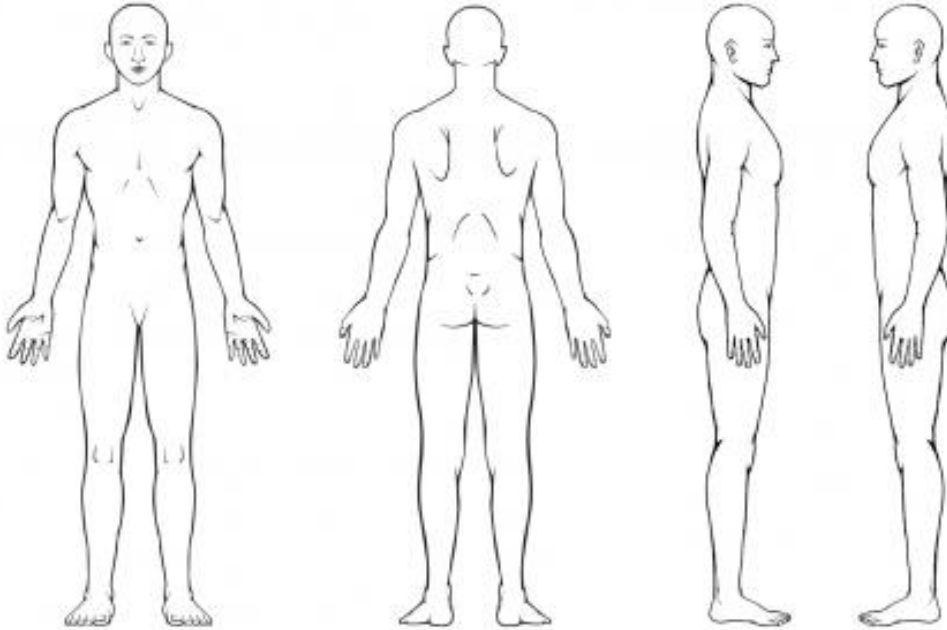
Additional information you feel is relevant: _____

Musculo-skeletal

___ Neck pain, stiffness

___ Multiple joint pain

___ Hip pain



___ Shoulder pain

___ Upper back

___ Low back

___ Sore muscles

___ Arthritis

___ Foot pain

___ Sciatica

Muscle weakness? ___

Muscle stiffness? ___

Limited range of motion? ___

Limited use/function? ___

Where? _____

Where? _____

Where? _____

Where? _____

Please indicate on the drawings below any areas of pain, discomfort