



Creative Life Institute
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New Patient Evaluation Form

Today's Date _____

LAST NAME	FIRST	MIDDLE	GENDER	SOC SEC #
ADDRESS	CITY	STATE	ZIP	PHONE #
REFERRED BY:	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> w			EMAIL
OCCUPATION (IF CHILD, PARENT) <input type="checkbox"/> STUDENT <input type="checkbox"/> RETIRED	BUSINESS NAME			WORK #
	BUSINESS ADDRESS			FAX #
IF CHILD, PARENT NAME	PARENT ADDRESS if different			PARENT #
SPOUSE NAME	SPOUSE EMPLOYER			SPOUSE WORK #
EMERGENCY CONTACT	ADDRESS			EMERGENCY CONTACT PHONE #
HAVE YOU HAD ACUPUNCTURE BEFORE?	HAVE YOU TAKEN HERBAL MEDICATIONS BEFORE?			

CURRENT / RECENT HEALTH CARE PROVIDERS • List Primary Care Physician First

HEALTH CARE SPECIALTY	NAME OF PROVIDER	ADDRESS	PHONE NUMBER

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Health concerns that brought you to *Time To Heal* in order of importance below.

Condition:

Treatments & Results

a. _____

History of Condition: *Describe how and when the problem began and progressed:*

How does this condition affect you- i.e. sleep, work, functional level? _____

Is it getting better or worse? _____

Condition:

Treatments & Results

b. _____

History of Condition: *Describe how and when the problem began and progressed:*

How does this condition affect you- i.e. sleep, work, functional level? _____

Is it getting better or worse? _____

Condition:

Treatments & Results

c. _____

History of Condition: *Describe how and when the problem began and progressed:*

How does this condition affect you- i.e. sleep, work, functional level? _____

Is it getting better or worse? _____

PAIN: 1=Mild 10=Excruciating

Characteristics of Pain	Comments/ Yes/ No	Duration of Pain	Comments/Yes/No	Better With/Y/N
Pain Level 1-10		Dull & Lingering		Exercise
Dull Ache		Intermittent		Rest
Sharp Local Pain		Constant		Pressure
Throbbing Pain				Heat
Deep Nagging Pain				Cold

MEDICAL HISTORY:

Current Medications/Dose/Frequency

Response to Medications

Current Supplements Dose/Frequency

Response to Supplements

DRUG ALLERGIES: Please list any, drugs, or medications you are hypersensitive or allergic to (please include reaction):

Allergies to Foods?

- Milk products
- Wheat or other grains
- Food dyes, additive
- Others

Allergies to Inhalants?

- Dust
- Grass. trees. pollen
- Animal dander
- Mold

Reactions to Chemicals?

- Chlorine, formaldehyde
- Cosmetics, detergents, perfumes
- Gas, glues, newsprint. paint, dye
- Smoke

Hospitalizations/Surgeries/Injuries (Sprains, Fractures, Dislocations & Scars)

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>

<u>TESTS</u>	<u>DATE RESULTS</u>	<u>TESTS</u>	<u>DATE RESULTS</u>
<input type="checkbox"/> EEG	<hr/>	<input type="checkbox"/> CT Scan	<hr/>
<input type="checkbox"/> EKG	<hr/>	<input type="checkbox"/> MRI	<hr/>
<input type="checkbox"/> EMG	<hr/>	<input type="checkbox"/> Stress Test	<hr/>
<input type="checkbox"/> SCAN	<hr/>	<input type="checkbox"/> X-rays	<hr/>

FAMILY HISTORY:

Check any that has affected your parents, grandparents, siblings, and children.

<u>Condition</u>	<u>Relative/s Affected</u>	<u>Condition</u>	<u>Relatives Affected</u>	<u>Condition</u>	<u>Relatives Affected</u>
<input type="checkbox"/> Addiction(s)	<hr/>	<input type="checkbox"/> Depression	<hr/>	<input type="checkbox"/> High Blood P.	<hr/>
<input type="checkbox"/> Allergies	<hr/>	<input type="checkbox"/> Diabetes	<hr/>	<input type="checkbox"/> Lung Problem	<hr/>
<input type="checkbox"/> Arthritis	<hr/>	<input type="checkbox"/> Digestive/Intestinal	<hr/>	<input type="checkbox"/> Overweight	<hr/>
<input type="checkbox"/> Asthma	<hr/>	<input type="checkbox"/> Genetic Disease	<hr/>	<input type="checkbox"/> Stroke	<hr/>
<input type="checkbox"/> Bladder	<hr/>	<input type="checkbox"/> Gout	<hr/>	<input type="checkbox"/> Thyroid	<hr/>
<input type="checkbox"/> Kidney	<hr/>	<input type="checkbox"/> Headache	<hr/>	<input type="checkbox"/> Suicide	<hr/>
<input type="checkbox"/> Bleeding	<hr/>	<input type="checkbox"/> Migraine	<hr/>	<input type="checkbox"/> Other	<hr/>
<input type="checkbox"/> Cancer	<hr/>	<input type="checkbox"/> Heart Disease	<hr/>	<input type="checkbox"/> Other	<hr/>

YOUR HISTORY: Check any of the following that you have now or ever have had.

- | | | | |
|---------------------------------------------|----------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema I Asthma | <input type="checkbox"/> Muscle Problems | <input type="checkbox"/> Thyroid: Hypo: <input type="checkbox"/> Hyper <input type="checkbox"/> |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Neurological Prob | <input type="checkbox"/> TMJ / Jaw Dysfunction |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Eye Problem | <input type="checkbox"/> Psychological Prob | <input type="checkbox"/> Viral: Herpes: <input type="checkbox"/> CMV: <input type="checkbox"/> |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Genetic Condition | <input type="checkbox"/> Respiratory Problems | Polio: <input type="checkbox"/> Mono: <input type="checkbox"/> |
| <input type="checkbox"/> Bladder/Kidney | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Scarlet Fever | How much? __ Time? __ |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexually Trans Dis | <input type="checkbox"/> Weight Gain: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sinus / Upper Respir | How much? __ Time? __ |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hormonal | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Eczema/Skin Prob | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Swallowing Problem | _____ |

Height: _____ / Weight: _____

Blood Pressure: _____

Cholesterol: _____

When was this reading taken? _____

LDL – HDL: _____

LIFESTYLE:

ACTIVITY LEVEL:

- Sedentary (inactive) by choice
- Sedentary (inactive) due to inability or restriction
- Light: light daily work and no regular exercise
- Moderate: light daily work and exercise 3 X week
- Sustained: moderate daily work and exercise 5 X week
- Heavy: heavy work and heavy exercise 5 X week

STRESSORS AFFECTING YOUR LIFE:

- Difficulties with work or lifestyle
- Recent change in marital status
- Death or serious illness family or friend
- Dysfunctional family Past Present
- Lack of love or fulfilling relationships
- Illness - self!

DIETARY HISTORY: How many servings and how often do you eat the following foods?

- | | | | |
|-----------------|------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| Dairy: | Milk, Cheese, Cottage Cheese, Yogurt | <input type="checkbox"/> Cow <input type="checkbox"/> Goat | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Protein: | Chicken, Turkey | <input type="checkbox"/> Fried | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Beef, Lamb, Pork, Veal, Liver | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Bacon, Bologna, Ham, Hot Dogs, Deli Meats | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Scale fish, Shell Fish, Mollusks | <input type="checkbox"/> Fried | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Bean, Peas, Lentils, Soy, Tofu, Nuts Seeds | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Grains: | Bread, Pasta, Crackers, Rice, Cereals | <input type="checkbox"/> White <input type="checkbox"/> Whole Grain | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Vegies: | Greens: Broccoli, Spinach, Kale, Lettuces | <input type="checkbox"/> Raw <input type="checkbox"/> Cooked | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Yellow: Carrots, Squash, Yams, Tomato | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Other: Potato, Beet, Celery, Artichoke, etc | <input type="checkbox"/> Raw <input type="checkbox"/> Cooked | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Fruits: | All varieties | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Sweets: | Cookies, Candy, Pastry, Jam, Syrup | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Oils: | Mayonnaise, Dressing, Oils | <input type="checkbox"/> Natural <input type="checkbox"/> Processed | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Fats: | Fats: Hydrogenated (margarine, Crisco), Butter | <input type="checkbox"/> Hydrog <input type="checkbox"/> Butter | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Other: | Ketchup, Steak Sauce, Soy Sauce | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Drink: | Water | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Natural Vegetable, Fruit Juices | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Soft Drinks | <input type="checkbox"/> Caffeine <input type="checkbox"/> Decaf | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Coffee, Teas | <input type="checkbox"/> Caffeine <input type="checkbox"/> Decaf | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Alcohol: Beer, Wine, Coolers, Hard Liquor | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |

Is your diet primarily Natural & Organic Prepared at Home Commercially Prepared Fast Food

REVIEW OF SYSTEMS

Please review carefully. Choose response that most closely matches your symptoms.

0 = Not present 1 = Mild or Occasional 2 = Moderate or Frequent 3 = Severe or Constant

Symptoms	0-3	Comments/Y or N	Symptoms	0-3	Comments/Y or N
Metabolism			Skin/Hair/Nails		
How is your appetite? Is it excessive?			Acne, Eczema, Dermatitis		
Any changes recently?			Brown Spots		
Any food cravings?			Itch Burning, Dry		
Any feeling of fullness after a meal? If so where?			Oily		
Any unusual taste in mouth? Ex: sour taste, bitter taste, metallic taste?			Pale		
Food Retention relieved by eating?			White Spots: Loss of Pigment		
Foul belching?			Yellow Tone		
Hunger with no desire to eat?			Nails: Brittle, Peeling		
Sour regurgitation after eating?			Ridges, White Lines		
Preference for hot or cold foods or drinks?			Head:		
Body Temperature			Ears/Eyes/Nose/Throat		
Any body chills?			Headaches		
Any Fever?			Migraines		
Alternating Chills & Fever			Head injury		
Afternoon Fever			Face / Jaw Pain/TMJ		
High fevers			Neck Pain, Stiff Neck		
Constant Fever rising during night			Hair. Brittle Dry		
Hot / Heat Intolerant			Hair -Loss of Color		
Cold/ Cold Intolerant			Hair Loss		
Cold Extremities					
Profuse Sweating			Ear Infections/purulent discharge		
Spontaneous sweating			Itching		
Night Sweating			Ringling – low pitch/gradual onset		
No Sweating			Ringling – high pitch/sudden onset		
Fluid Intake/Thirst			Dizzy/Vertigo		
Prefer hot or cold drinks			Red eyes /swelling		
Lack of thirst			Blurred Vision/Dry/Itching		
Thirsty with no desire to drink			Itchy		
Thirst with desire to drink slowly			Floaters (see spots)		
Increase in thirst			Glaucoma / Retina Problems		
Lung/Respiratory System			Light Sensitive		
Asthma			Night Blind		
Forceful/coarse breathing			Cataracts		
Feeble breathing			Red throat with yellow or white ulcer spots		
Bronchitis			Bright red throat/mild soreness		
Chest pain			Voice Hoarse		
Colds + Flu (frequency)			Cough - chronic		
Shortness of Breath			Productive cough		
Exercise Induce Problems			Blood streaked cough		
Gastrointestinal Tract			Tickle in throat		
Belching, Bloating, Gas			Nasal		
Constipation			Bleeds		
Constipation with abdominal pain			Burning / Dryness / Crusts		
Loose stools			PND/ Rhinitis		
Diarrhea			Sinusitis		
			Clear nasal discharge or turbid nasal discharge		

Diarrhea early morning only			Bleeding Gums/swelling and red		
Dark Stool			Bone Loss (Periodontitis)		
Blood in Stool			Bruxism (Grinding)		
Mucous in Stool			Mouth Ulcers		
Vomiting			Swallowing Problem		
Watery stool with undigested food			Taste Loss		
Small bitty stools			Any unusual taste in mouth		
Any strong smell			Any bitter taste in mouth		
Hemorrhoids/Rectal Bleed					
Colitis / Irritable Bowel					
Gastritis, Pain, Ulcer					
Heartburn, Reflex					
Symptoms	0-3	Comments/Y or N	Symptoms	0-3	Comments/Y or N
Cardiovascular			Male		
High Blood Pressure			Discharge		
Chest Pain			Impotence		
Dizzy Spells			Lumps		
Leg Pain With Walking			Pain- Testicular		
Numb Extremities			Prostate Problems		
Palpitations / Tachycardia			Weak Urine Stream		
Stroke			STD's		
Varicosities			Female		
Musculoskeletal			Breasts: Cancer		
Arthritis/Joint Pain			Fibrocystic		
Back Pain / Disc Problems			Sore		
Bursitis/Tendonitis			Endometriosis		
Muscle Aches / Pains			Fibroids / Cysts		
Muscle Cramps / Spasms			Hormone Replacement		
Muscle Weakness			Hot Flashes		
Neurological			Infertility		
Loss of balance			Peri-menopausal		
Convulsions / Seizures			Menopausal: Natural		
Fainting Spells			Surgical		
Neuralgia I Tingling			Night Sweats		
Numbness			Osteoporosis		
Spastic Motion / Tremors			Ovarian/Uterine Cancer		
			Painful Intercourse		
Urinary Tract			Pap Smears - abnormal		
Color of Urine:			Cycle – irregular- sometimes early –sometimes late		
Yellow			Cycle less than 28 days		
Clear and profuse			Cycle greater than 35 days		
Turbid color			Cycle Early by 7/8 days		
Large amounts or scanty amounts			Cycle late by 8/9 days		
Blood in Urine			Heavy Flow/Light Flow		
Frequent Urination			Color- light red, red, purple		
Incontinence			Consistency – thin, thick, clots		
Strong odor to urine			Cramps		
Urinary Tract Infections			PMS Symptoms		
Any Pain before or after or during			Bloating,mood swings,HA		
Sleep			Acne, low backaches,		
Difficulty falling asleep			Weight gain, water retention		
Restless sleep			Pregnancies: Incomplete		
Waking in the night			Full Term		
# of times awakened			Infection		
How many hours			Inflammation		
Any recurring dreams or nightmares			Yeast		
Wake up refreshed?			Sexually Transmitted Dis.		
			Vaginal: Dryness		

