ID Acupuncture

13851 E14TH Street Suite203
San Leandro, Ca 94578

www.idacupuncture.com
Ph 510-895-8912 Fax 510-895-8930

INITIAL SELF EVALUATION FORM

Name___________________________________ **Date** ___________________

Please tell us about yourself, so that we can serve you better. If you have difficulty answering any question, or if it doesn't apply to you, just leave it blank. You will have ample opportunity to clarify or explain any of your answers during your evaluation and treatment sessions.

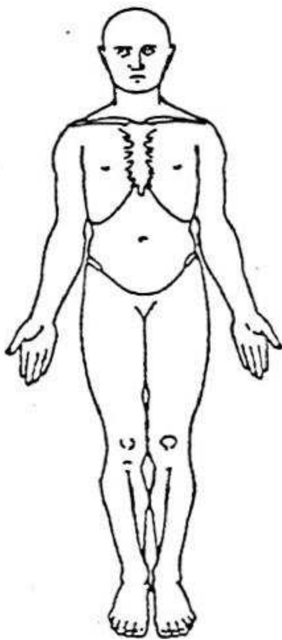
Who referred you to us? ____

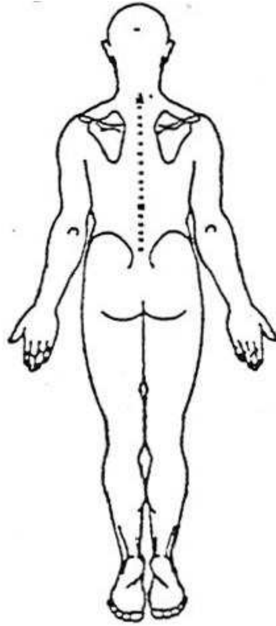
What is your reason for seeking therapy? ____

____

Please mark or shade in any areas where you have been experiencing discomfort. You can label each area with one or more descriptor from the following list:

Severe	Sharp	Burning	Aching
Moderate	Dull	Throbbing	Stabbing
Numbness/tingling	Weakness	Radiating (indicate direction with arrow)	





List & rate each symptom you have been experiencing. Rate on a scale of 0-10, 0 is no pain-10 the worst pain you can imagine.

a. ____ 0 1 2 3 4 5 6 7 8 9 10

b. ____ 0 1 2 3 4 5 6 7 8 9 10

c. ____ 0 1 2 3 4 5 6 7 8 9 10

d. ____ 0 1 2 3 4 5 6 7 8 9 10

When did your symptoms begin? ____

What do you think causes your symptoms? ____

What makes your symptoms worse? Sitting __ Standing __ Bending __ Lifting __ Walking __ Running __

Other, describe: ____

What eases your symptoms?____

Please describe the daily pattern of your symptoms. Type and severity of discomfort.

First thing in the morning?____

Later morning? ____

Late afternoon? ____

Evening? ____

Is your sleep pattern disturbed?____

How many hours of sleep do you typically have per night? ______________________

Have you been seen by a physician for these symptoms? If so, what was the diagnosis? ____________

Have you had any diagnostic tests done? (X-rays, MRI, EMG/NCV, etc.) If so what were the results? *(If you have access to any reports or films, it would be helpful to bring them in.)* ______________________

____

Have you had any previous treatment for this condition? (Previous Physical Therapy, chiropractic, massage, etc.)

What were the results? ____

____

Are you presently taking any medications? Please list. ______________________

What is your occupation? ____

How much, if any, is your work affected by your condition?______________________

What recreational or leisure activities do you enjoy? ______________________

Describe your types and amounts of routine exercise? ______________________

Are these affected by your condition? ____

Please describe your goals for your treatment? ______________________________

____

How much time (per day or per week) are you willing to commit to improve your symptoms?

____

Other Comments:

____