

# Hope Acupuncture and Wellness LLC

(Initial Assessment Form)

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Sex M F

DOB \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SS# \_\_\_\_\_ Married Single Divorced

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone Number (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Would you like to subscribe to our Monthly Newsletter? Yes No

How did you find us? Dr. \_\_\_\_\_ / Patient \_\_\_\_\_ / Online / Insurance

## PHONE NUMBERS

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

## INSURANCE INFORMATION

Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Company ID: \_\_\_\_\_ /Policy #: \_\_\_\_\_

List any surgeries that you've had (Include the year of the surgery):

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**List all medications and supplements you are taking, including length of use:**

Medications (please give name, dose and amount of time on med)

Med \_\_\_\_\_ Dose \_\_\_\_\_ Length of use? \_\_\_\_\_  
Med \_\_\_\_\_ Dose \_\_\_\_\_ Length of use? \_\_\_\_\_  
Med \_\_\_\_\_ Dose \_\_\_\_\_ Length of use? \_\_\_\_\_  
Med \_\_\_\_\_ Dose \_\_\_\_\_ Length of use? \_\_\_\_\_

Vitamins, Herbs, Minerals

Name/Brand \_\_\_\_\_ Length of use \_\_\_\_\_  
Name/Brand \_\_\_\_\_ Length of use \_\_\_\_\_  
Name/Brand \_\_\_\_\_ Length of use \_\_\_\_\_

**Chief Complaint:** \_\_\_\_\_

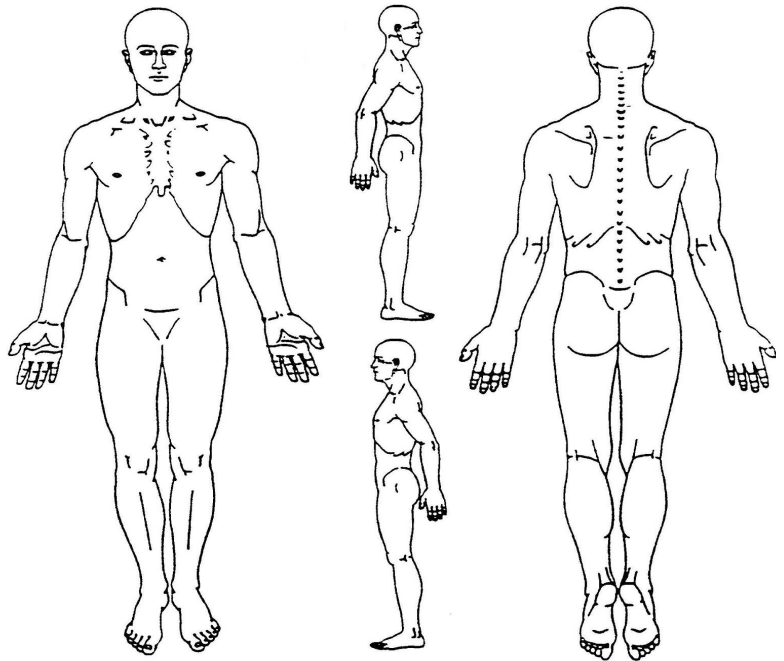
Onset of present condition: \_\_\_\_\_

Diagnosis by family physician or specialists: \_\_\_\_\_

What treatment you have received:

Medication / Surgery / Physical Therapy / Chiropractic Services / Other

On the picture to your right,  
please indicate all areas of  
discomfort or pain by marking  
them with an X.



# SYMPTOMS

Please circle any of the following symptoms you have been experiencing.

## Eyes, Ears, Head and Neck

Glaucoma  
Tearing/Dryness  
Impaired Hearing  
Ear Ringing  
Headaches/Migraines  
Sinus Problems  
Frequent Sore Throats  
TMJ/Jaw Problems

## Emotional

Mood Swings  
Anxiety  
Depression  
Panic Attacks  
Major Trauma  
Nervousness  
Poor memory  
Psychiatric Care

## Muscle, Joints & Bones

Muscle Cramping Symptoms  
Swollen Joints Arthritis/Joint  
Pain Herniated Disk  
Tendonitis Repetitive Strain  
Rheumatism

## Gastrointestinal

Ulcers  
Changes in Appetite  
Nausea/Vomiting  
Epigastric Pain Passing  
Gas Heartburn Belching  
Gallbladder Disease Liver  
Disease Hepatitis B/C  
Abdominal Pain

## Energy and Immunity

Aids/HIV Chronic  
Infections Chronic  
Fatigue Syndrome

## Female Reproductive

Painful Intercourse  
Breast  
Lumps/Tenderness  
Nipple Discharge  
Menopausal Symptoms  
Irregular Cycles  
Heavy Flow  
Clotting  
Difficulty Conceiving  
Painful Periods  
Bleeding Between Cycles

## Cardiovascular

HearDisease Chest  
Pain Swelling of  
Ankles High Blood  
Pressure  
Palpitations/Fluttering

## Respiratory

Shortness of Breath  
Frequent Common  
Colds Difficulty  
Breathing  
Emphysema  
Persistent Cough  
Asthma Tuberculosis

## Endocrine

Feeling Hot/Cold  
Night Sweats  
Diabetes Mellitus  
Hypothyroid  
Hyperthyroid

## Urino-Genital

Kidney Disease  
Painful Urination  
Frequent UTI  
Frequent Urination  
Kidney Stones  
Impaired Urination  
Blood In Urine  
Frequent Urination at  
Night

## Neurological

Vertigo/Dizziness  
Paralysis Parkinson's  
Disease Nerve  
Pain/Damage  
Seizures/Epilepsy  
Psychiatric Care  
Endocrine  
Numbness/Tingling  
Loss of Balance

## Skin and Hair

Psoriasis  
Skin Rashes  
Itching  
Acne  
Eczema  
Hives  
Hair Loss