Jipala Reicher-Kagan M.S., L.Ac
Transpersonal Acupuncture
Evaluation Form

Name____ Date____/___/___

Address____ Age____ Sex Male___ Female___

City State ____ Zip Code______ Date of Birth___/___/___

Telephone H:______________ W:________________ C:________________ Email______________________

Referred by____

Physician____ Telephone________________________

Have you ever had acupuncture before?___________ Occupation______________________

What do you want treated with acupuncture?____

How long have you had this condition?______________________ Was the onset Sudden___ Gradual___

Symptoms relieved by________________________ Symptoms worsened by__________________________

What medical diagnosis have you received?____

What other treatments have you received recently for this and/ or other conditions? ______________________

____

What medications, supplements, homeopathics, herbs are you presently taking? (Please include the dosage) _________
____

____

Past Medical History
Have you had any of these? Please check ALL that apply.

___ AIDS/HIV ___ Cancer ___ Lyme Disease ___ Seizures
___ Alcoholism ___ Diabetes ___ Multiple Sclerosis ___ Tuberculosis
___ Allergies ___ Emphysema ___ Pacemaker ___ Latex Allergy
___ Asthma ___ Heart Disease ___ Polio ___ Lymph Nodes Removed
___ Birth Trauma ___ Hepatitis A B C ___ Rheumatic Fever ___ Herpes
___ Coffee Drinker ___ Smoker ___ Fibromyalgia ___ Scarlet Fever
___ Blood Pressure___ Prescription Drug User

Other____________________________

Are you currently pregnant?____________
Are you presently trying to get pregnant?____________

Describe any significant injuries, surgeries, or major illnesses, whether hospitalized or not and the dates (please include any significant childhood illnesses):

Emotions & Sleep

How do you feel emotionally?____

Do you have (Check ALL that apply)

___Panic Attacks ____ Depression ___Anxiety ___Bad Temper ___Nervousness

___ Poor memory ____ Difficulty concentrating

How long do you normally sleep? _____ hours per night

I have difficulty with (Check ALL that apply) ___ Falling asleep ___ Staying asleep ___ Disturbed sleep

___ Vivid Dreams ___ Wake up frequently during the night

Gastrointestinal

I have (Check ALL that apply) ___ Belching ___ Nausea ___ Vomiting ____ Vomiting Blood

___ Ulcers ___Bloating ____ Regurgitation ___ Acid ____ Heartburn ____ Indigestion

___ Severe Stomach Pain ____ Other____

Bowel Movements How often?___________ Day/Week

Painful Bowel Movements How often?______ Day/Week

I have (Check ALL that apply) ___Irregular elimination ___ Constipation ___Diarrhea ___Gas

____ Burning ___ Hemorrhoids ____Use Laxatives ____Undigested food in stool ____ Loose stool

____ Hard stool ____Blood in stool ___ Itchiness ____ Other________________________________

Urinary & Genital

I have or have had (Check ALL that apply) ____Trouble starting a stream ____ Frequent urination

___ Incontinence ___Pain ____ Trouble holding urine ____ Burning ____ Dribbling when sneezing

____ Urinary tract infections ____ Blood in urine ____Kidney stones ____ Irritation when urinating

____Other____

Do you have (Check ALL that apply) ____ Infertility ____Pain during sexual relations ____ Other_______

Women

At what age did you start menstruating?_________________ Number of days between cycles?___________

Number of days of flow_____________________________ Color__________________________________

I have or have had (Check ALL that apply) ___Irregular menstruation ____Heavy flow ____ Light flow

___No flow ___Clots ____ Vaginal itching/burning ____Spotting between periods
____ Discomfort/ pain before periods ____ Discomfort/ pain during periods ____ Other

Any vaginal discharge ___ yes ____ no Amount __________ Color_________ Frequency___________

PMS Symptoms____

Number of pregnancies _______ Number of deliveries_________ Abortion (s)/ Miscarriage (s)___________

Menopausal Symptoms____

Men

I have (Check ALL that apply) ____ Prostatitis ____ Impotence ____ Penis blood/ mucous discharge
____Other

Muscles, Joints & Bones

Do you have pain or tightness? _______ Where____

The pain is (Check ALL that apply) ____ Sharp ____ Aching ____Numb ____Deep pain ____ Burning
____ Dull ____Superficial pain ____ Tingling _____ Pain worse/ Better with cold
____Pain worse/ Better with heat ____ Pain Worse/ Better with pressure ____ Pain Worse AM/PM

I have (Check ALL that apply) ____ Swollen joints ____ Arthritis/ joint pain ____ Tendonitis
____ Rheumatism ____ Bone pain ____ Muscle pain ____ Repetitive strain injury
____ Other____

Respiratory, Eyes, Ears, Nose, Throat & Head

Do you smoke? ___Yes ___No How many a day?________ For how many years__________

I have (Check ALL that apply) ___ Frequent colds ____ Chronic runny nose ____ Chronic cough
____ Coughing blood ____ Pain Inhaling ____ Shortness of breath on exertion/ at rest ____ Asthma
____ Nose Bleeds ____ Pain/ red eyes ____ Poor vision ___ See spots ____Dizziness ____Cold sores
____ Bleeding gums ____ Dry mouth ____ Frequent sore throat ____Ear pain _____ Ringing in ears
____ Clogged /popping ears ____Frequent sore throat ____ Cough up mucous How much?__________

Color of phlegm? _________________ Frequent headaches/ Migraines Describe ______________________

____

Other____

Cardiovascular

Blood Pressure_________/__________ Have you ever been diagnosed with heart trouble?__________

I have (Check ALL that apply) ___ Chest pain ___Palpitations ____ Varicose veins ____Plebitis
___Cold hands/ feet ___ Irregular heart beat ____ Poor circulation ____ Other _________________________

Skin and Hair

I have or often have (Check ALL that apply) ___Dry skin ___ Skin rashes ___Itching ___Acne ___Eczema
___Hives ___Hair loss _____Premature graying ___ Other ____

Family Medical History (Please list any significant family illnesses)

Mother____

Father____

Siblings____

Grandparents____

Is there anything else that you would like to include?