Pure Health ACUPUNCTURE LLC
A Natural Healing and Wellness Center

Assessment Form

Patient Name_____ Date_____

Check all that apply

1. Heat/Cold

☐ Aversion to cold/wind
☐ Aversion to heat

Do you typically feel

☐ Cold
☐ Hot
☐ Neither, but with cold hands and feet

2. Perspiration

☐ Night sweats
☐ Day sweats (I perspire during the day even if it isn't hot and I'm not exerting myself)
☐ Sweating of the palms and soles of feet, chest, and top of head

3. Head/Body

☐ Do you have headaches? If so, how often? _____
Where do you mostly feel them? (Circle)
Forehead / Side of head / Top of head / Base of skull

☐ Acid reflux/Gerd
☐ Anxiety
☐ Arthritis
☐ Bitter or metallic taste in mouth
☐ Bleeding gums
☐ Bunions, heel spurs, or hammertoe
☐ Cancer
☐ Carpal tunnel syndrome
☐ Depression
☐ Diabetes
☐ Dizziness/vertigo
☐ Dry, brittle, hair or nails
☐ Dry skin, eczema, or psoriasis
☐ Heel pain
☐ Heart palpitations
☐ High blood pressure
☐ Knee pain
☐ Mid or low back pain
☐ Plantar fasciitis or neuropathy
☐ Restless leg syndrome
☐ Thyroid problems
☐ Tightness or pain of neck and shoulders
☐ Other

4. Chest/Abdomen

- ☐ Intercostal pain/pressure (muscles between the ribs)
- ☐ Gurgling or bloating in abdomen
- ☐ Difficulty inhaling or exhaling
- ☐ Asthma
- ☐ Phlegm
- ☐ Cough

5. Hunger/Thirst

- ☐ Lack of hunger
- ☐ Lack of thirst
- ☐ Insatiable appetite
- ☐ Hunger with no appetite
- ☐ Preference for cold drinks
- ☐ Preference for warm drinks
- Cravings (Circle)
  Sweet / Salty / Other _____

6. Urination/Stool

- Urine color (Circle)
  Clear / Yellow / Brown
- Frequency of bowel movements (circle)
  Three times a day / Two times a day / Once a day / Every other day / Every three days / Other_____
- ☐ Diarrhea
- ☐ Loose stools
- ☐ Formed stools
- ☐ Urge to have a bowel movement in the morning
- ☐ Hard stools/pellets
- ☐ Incontinence
- ☐ Dribbling urination

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7. Vision/Hearing

- ☐ Floaters in eyes
- ☐ High pitched ringing in ears
- ☐ Low pitched ringing in ears
- ☐ Blurry vision
- ☐ Hearing loss

8. Sleep

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep (Circle reason) Busy mind / pain / need to urinate
- ☐ Vivid dreams (colorful, disturbing, and lifelike)
- ☐ Excessive desire to sleep

9. Reproductive - Women

- ☐ Cycle is _____ days
- ☐ Period lasts _____ days
- ☐ Cramps
- ☐ Clotting
- ☐ Bright blood
- ☐ Dark blood
- ☐ Bowel movements become more frequent during period
- ☐ History of endometriosis
- ☐ History of cancer
- ☐ Hysterectomy
- ☐ Low libido

9. Reproductive - Men

- ☐ Prostate Health
- ☐ Erectile dysfunction
- ☐ Low libido

10. Constitution

Do you wake up rested after a full night's sleep? (Circle)
Yes / No

On a scale of 1-10 how do you feel, emotionally and physically, when you wake up in the morning (Circle)
1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10