All Information is Strictly Confidential

Date: ___________________ Name: ____

Address: ____

City, State, Zip: ____

Home Phone: _____(_____)_______________________ Cell Phone: (___________)________________

E-mail: ____

Date of Birth: ___________/_____/______ Gender: __________ Height: __________ Weight: __________

How did you hear about Rock Creek Acupuncture? _______________________________________

Guardian Name (required if under 18): ____

Emergency Contact: _______________________ Phone: ____

Jason Burke, L.Ac. **7525 8th St. NW, Washington, DC 20012**
(202) 309-4958 **Jason@rockcreekacupuncture.com**

Medical History

Check any you have had:

- ☐ Diabetes
- ☐ Heart Diseases
- ☐ Asthma
- ☐ Jaundice
- ☐ Syphilis
- ☐ Meningitis
- ☐ Epilepsy
- ☐ Paralysis
- ☐ COPD
- ☐ Stroke
- ☐ Pneumonia
- ☐ HIV
- ☐ Cancer
- ☐ Hepatitis
- ☐ TB
- ☐ Thyroid Disorder
- ☐ Mononucleosis
- ☐ Emphysema
- ☐ Multiple Sclerosis
- ☐ Hypertension
- ☐ Kidney disease

Main Complaint:

____

____

____

____

What medical diagnosis, lab tests, and/or imaging have you received:

____

____

____

____

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Brief History of Main Complaint:

Allergies / Food Intolerances:

What alleviates or lessens your symptoms (e.g. cold, heat, rest, exercise, OTC medicine):

What aggravates your symptoms?

Current medications / Supplements

Past Surgeries

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Please check all appropriate boxes.

Joint Pain

Neck: Sharp ☐ Dull ☐ Heavy ☐ Tight ☐ Swelling ☐ Other _________ Frequency__ ______

Shoulder: Sharp ☐ Dull ☐ Heavy ☐ Tight ☐ Swelling ☐ Other _________ Frequency__ ______

Elbow: Sharp ☐ Dull ☐ Heavy ☐ Tight ☐ Swelling ☐ Other _________ Frequency__ ______

Wrist: Sharp ☐ Dull ☐ Heavy ☐ Tight ☐ Swelling ☐ Other _________ Frequency__ ______

Hand: Sharp ☐ Dull ☐ Heavy ☐ Tight ☐ Swelling ☐ Other _________ Frequency__ ______

Hip: Sharp ☐ Dull ☐ Heavy ☐ Tight ☐ Swelling ☐ Other _________ Frequency__ ______

Knee: Sharp ☐ Dull ☐ Heavy ☐ Tight ☐ Swelling ☐ Other _________ Frequency__ ______

Ankle: Sharp ☐ Dull ☐ Heavy ☐ Tight ☐ Swelling ☐ Other _________ Frequency__ ______

Foot: Sharp ☐ Dull ☐ Heavy ☐ Tight ☐ Swelling ☐ Other _________ Frequency__ ______

Other: ____

Other: ____

Headaches: Frontal ☐ Sides ☐ Behind Eyes ☐ Sharp ☐ Dull ☐ Heavy ☐ Tight ☐ Migraines ☐

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ROCK CREEK ACUPUNCTURE & CHINESE MEDICINE

MUSCLES

Indicate Areas Involved

- Muscle Cramping ☐
- Weakness ☐
- Tremors ☐
- Tightness ☐
- Inflexibiity ☐

SLEEP

Good	☐	Poor	☐	Interuppted by:			
Easy to Fall	☐	Hard to Fall	☐	Superficial	☐	Deep	☐
Dreamful	☐	Restless	☐	Wake Rested	☐	Wake Tired	☐

ENERGY

Restless	☐	Lethargic	☐	Neutral	☐	Drops after Lunch	☐
Low in AM	☐	Low in PM	☐	High in AM	☐	High in PM	☐

TEMPERATURE	Cold	Cool	Neutral	Warm	Hot
Body	☐	☐	☐	☐	☐
Hands / Arms	☐	☐	☐	☐	☐
Feet / Legs	☐	☐	☐	☐	☐

WEATHER DISLIKES

Cold ☐ Hot ☐ Damp ☐ Wind / Air Con ☐

SWEATING

Frequent	☐	Copious	☐	Absent	☐	After eating	☐
Odorous	☐	Night Sweats	☐				

SKIN (Indicate Locations)

Acne ______ Rashes ______ Psoriasis ______

Dryness ______ Itching ______

ROCK CREEK
ACUPUNCTURE
& CHINESE MEDICINE

HEAD

Headaches	☐	Migraines	☐	Dizziness	☐	Vertigo	☐
Lightheadedness	☐	Heaviness	☐	Clouded Thinking	☐	Poor Memory	☐

EYES

Blurry Vision	☐	Floaters	☐	Dry	☐	Tearing	☐
Sensitive to Wind	☐	Redness	☐	Itching	☐	Light Sensitive	☐

NOSE

Runny	☐	Stuffed	☐	Dry	☐	Bleeds Often	☐
Sneezing	☐						

SINUS

Blocked	☐	Painful	☐	Frequent Infections	☐

EARS

Ringing	☐	Blocked	☐	Deafness / Loss of hearing	☐

MOUTH

Dry	☐	Excess Saliva	☐	Bitter Taste	☐	Metallic Taste	☐
Unclean Taste	☐	Bad Taste	☐	Sour Taste	☐	Sweet Taste	☐
Salty Taste	☐	Dry Lips	☐	Bleeding gums	☐	Mouth Ulcers	☐

THROAT

Dry	☐	Swollen	☐	Phlegm Stuck In	☐	Lump	☐
Hard to Swallow	☐	Post Nasal Drip	☐				

CHEST

Tightness	☐	Palpitations	☐	Tachycardia	☐	Cough	☐
Wheezing	☐	Shortness of Breath	☐	Breast Pain	☐	Flank / Side Pain	☐

THIRST

Often Thirsty	☐	Normal	☐	Never Thirsty	☐	Avoid liquids	☐
Thirsty with no desire to drink			☐	Forget to drink	☐		

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ROCK CREEK ACUPUNCTURE & CHINESE MEDICINE

Prefer Warm ☐ Prefer Cold ☐ Prefer Room Temp ☐

Drinks / day ____ Alcohol / day ____ Coffee / day ____ Tea / day ____

APPETITE

High Appetite ☐ Low Appetite ☐ No Appetite ☐ Avoid foods ☐

Forget to eat ☐

DIGESTION

Bloating ☐ Gas ☐ Pain after eating ☐ Indigestion ☐

Belching ☐ Heartburn ☐ Heavy sensation ☐ Nausea ☐

DIET

1-2 meals / day ☐ 2-4 meals / day ☐ >4 meals /day ☐

Diet Followed: None ☐ Paleo ☐ Vegetarian / Vegan ☐

Gluten Free ☐ Other: ____

ELIMINATION

Urination Times per day ____ Times per night ____

Clear ☐ Light ☐ Dark ☐ Contains Blood ☐

Strong Smell ☐ Weak Smell ☐ No Smell ☐ Interuppted ☐

Profuse ☐ Scant ☐ Incomplete ☐ Weak Stream ☐

Strong Stream ☐ Painful ☐ Burning ☐ Frequent UTIs ☐

Bowels Times per day ____ or Times per week ____

Formed ☐ Loose ☐ Hard ☐ Soft ☐

Liquid ☐ Dry ☐ Diarrhea ☐ Constipation ☐

Difficult ☐ Incomplete ☐ Strong Smell ☐ Weak Smell ☐

Contains Blood ☐ Contains Mucous ☐ Hemorrhoids ☐ Anal Prolapse ☐

EMOTIONS MOST FREQUENTLY EXPERIENCED

Joy ☐ Anger ☐ Sadness ☐ Depression ☐

Numbness ☐ Irritation ☐ Content ☐ Discontent ☐

Sensitive ☐ Moody ☐ Irritation ☐ Disconnected ☐

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MENSTRUAL CYCLE

Regular ☐ Irregular ☐ Average Days Between Cycles ______

Last Menstrual Period ______ Cycle Day ______

PMS

Bloating ☐ Breast Distention ☐ Back Pain ☐ Leg Pain ☐

Cramping ☐ Nausea ☐ Fatigue ☐

BLOOD **Number of Days Bleeding**

Dark ☐ Light ☐ Brown ☐ Purple ☐

Contains Clots ☐ Contains Mucous ☐ Spotting between cycles ☐

GYNECOLOGICAL (other)

Fibroids ☐ Cysts ☐ Low Libido ☐

Other ______

MENOPAUSE

Hot flashes ☐ Night Sweats ☐ Pain during Intercourse ☐

Vaginal Dryness ☐ Mood Changes ☐ Other ______

MALE

Impotence ☐ Soft Erections ☐ Enlarged Prostate ☐ Inflamed Prostate ☐

Painful Prostate ☐ Premature Ejaculation ☐ Spermattorhea ☐

Low Libido ☐ Scrotal Pain ☐ Scrotal Itching ☐ Scrotal Dampness ☐

SPERM

Unknown ☐ Low Count ☐ Low Motility ☐ Poor Morphology ☐

ADDITIONAL NOTES, COMMENTS, CONCERNS:

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