



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.
(202) 309-4958

7525 8th St. NW, Washington, DC 20012
Jason@rockcreekacupuncture.com



Medical History

Check any you have had:

- | | | |
|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Heart Diseases | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> TB | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid Disorder | |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Mononucleosis | |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Emphysema | |

Main Complaint:

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



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



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

Jason Burke, L.Ac.
(202) 309-4958

7525 8th St. NW, Washington, DC 20012
Jason@rockcreekacupuncture.com

MUSCLES

Indicate Areas Involved

- Muscle Cramping
- Weakness
- Tremors
- Tightness
- Inflexibility

SLEEP

- | | | | | | | | |
|--------------|--------------------------|--------------|--------------------------|-----------------|--------------------------|------------|--------------------------|
| Good | <input type="checkbox"/> | Poor | <input type="checkbox"/> | Interrupted by: | <input type="text"/> | | |
| Easy to Fall | <input type="checkbox"/> | Hard to Fall | <input type="checkbox"/> | Superficial | <input type="checkbox"/> | Deep | <input type="checkbox"/> |
| Dreamful | <input type="checkbox"/> | Restless | <input type="checkbox"/> | Wake Rested | <input type="checkbox"/> | Wake Tired | <input type="checkbox"/> |

ENERGY

- | | | | | | | | |
|-----------|--------------------------|-----------|--------------------------|------------|--------------------------|-------------------|--------------------------|
| Restless | <input type="checkbox"/> | Lethargic | <input type="checkbox"/> | Neutral | <input type="checkbox"/> | Drops after Lunch | <input type="checkbox"/> |
| Low in AM | <input type="checkbox"/> | Low in PM | <input type="checkbox"/> | High in AM | <input type="checkbox"/> | High in PM | <input type="checkbox"/> |

TEMPERATURE

- | | | | | | |
|--------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Cold | Cool | Neutral | Warm | Hot |
| Body | <input type="checkbox"/> |
| Hands / Arms | <input type="checkbox"/> |
| Feet / Legs | <input type="checkbox"/> |

WEATHER DISLIKES

- | | | | | | | | |
|------|--------------------------|-----|--------------------------|------|--------------------------|----------------|--------------------------|
| Cold | <input type="checkbox"/> | Hot | <input type="checkbox"/> | Damp | <input type="checkbox"/> | Wind / Air Con | <input type="checkbox"/> |
|------|--------------------------|-----|--------------------------|------|--------------------------|----------------|--------------------------|

SWEATING

- | | | | | | | | |
|----------|--------------------------|--------------|--------------------------|--------|--------------------------|--------------|--------------------------|
| Frequent | <input type="checkbox"/> | Copious | <input type="checkbox"/> | Absent | <input type="checkbox"/> | After eating | <input type="checkbox"/> |
| Odorous | <input type="checkbox"/> | Night Sweats | <input type="checkbox"/> | | | | |

SKIN (Indicate Locations)

- | | | | | | |
|---------|----------------------|---------|----------------------|-----------|----------------------|
| Acne | <input type="text"/> | Rashes | <input type="text"/> | Psoriasis | <input type="text"/> |
| Dryness | <input type="text"/> | Itching | <input type="text"/> | | |

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

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 Interrupted
 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

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 Spermatorrhea
 Low Libido Scrotal Pain Scrotal Itching Scrotal Dampness

SPERM

Unknown Low Count Low Motility Poor Morphology

ADDITIONAL NOTES, COMMENTS, CONCERNS: