Abigail Thomas Costello MS, LAc, LMT
309 N. Tioga Street
Ithaca, NY 14850
607-274-7520

Initial Evaluation

I. Patient Information

Name:_____ Today's Date:_____

Address: _____ Home Phone:_____

_____ Mobile Phone:_____

Occupation:_____ Work Phone: _____ Employer:

_____ Email:_____

Age: _____ DOB:___/____/_____ ☐M ☐F Height: _____ Weight_____

II. Present Health Concerns: Please list your concerns that bring to you here today in order of importance

1. Approx Date of Onset :

Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Other therapies tried: ☐Medication ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other_____

2. Approx Date of Onset :

Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Other therapies tried: ☐Medication ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other_____

Current Physician: _____ Physician's Phone_____

Have you had acupuncture before? ☐Yes ☐No Chinese Herbal Medicine? ☐Yes ☐No

III. Health History:

Please fill out the following two pages to help me evaluate you. In Part One, place a checkmark indicating if you (Self) or a family member (Fam) had the following illnesses. In Part Two, indicate if you experience a symptom NOW or had it in the PAST (please indicate year).

1. Diagnosed illnesses

Self	*Fam*	**Condition**
__	__	AIDs/ HIV
__	__	Alcoholism
__	__	Alzheimer's
__	__	Anemia
__	__	Arthritis
__	__	Asthma
__	__	Cancer _____
__	__	Chronic Fatigue Syndrome
__	__	Clinical Depression
__	__	Diabetes Type I
__	__	Diabetes Type II
__	__	Eczema
__	__	Emphysema
__	__	Epilepsy
__	__	Fibromyalgia
__	__	Gall Bladder Stones
__	__	Glaucoma
__	__	Goiter
__	__	Gout
__	__	Heart Disease
__	__	Hepatitis A
__	__	Hepatitis B
__	__	Hepatitis C
__	__	Herpes
__	__	Hyperthyroid
__	__	Hypertension
__	__	Hypothyroid
__	__	Irritable Bowel Syndrome
__	__	Leaky Gut Syndrome
__	__	Lupus
__	__	Measles
__	__	Multiple Sclerosis
__	__	Mumps
__	__	Pleurisy
__	__	Psoriasis
__	__	Schizophrenia
__	__	Stroke
__	__	TMJ
__	__	Tuberculosis
__	__	Ulcers
__	__	Urinary Tract Infection
__	__	Venereal Disease
__	__	Whooping Cough

Self	*Fam*	**Condition**
__	__	Osteoporosis
__	__	Strong thirst
__	__	Weight loss/ gain
__	__	Poor Sleep
__	__	Heavy Sleep
__	__	Insomnia

Now	*Past*	**General Symptoms**
__	__	Poor Appetite
__	__	Heavy Appetite
__	__	Changes in appetite
__	__	Cravings

2. Symptoms

__	__	Dream-disturbed sleep
__	__	Night Sweats
__	__	Fatigue, low energy

Time of Day?_____

__	__	Weakness

Abigail Thomas Costello MS, LAc, LMT
309 N. Tioga Street
Ithaca, NY 14850
607-274-7520

Initial Evaluation

__ __ Dizziness
__ __ Tremors
__ __ Fever/ Chills
__ __ Sweat easily
__ __ Don't sweat enough
__ __ Other_____

Now Past **Skin and Hair**
__ __ Rashes/ Hives
__ __ Itching
__ __ Dry Skin
__ __ Dry hair
__ __ Dandruff
__ __ Ulcerations
__ __ Loss of Hair
__ __ Pimples/ Acne
__ __ Fungal Infections
__ __ Recent Moles
__ __ Change in skin/hair texture
__ __ Bruise easily
__ __ Nails weak, ridged or split
__ __ Athletes foot

Now Past **Head, Eyes, Ears, Nose, Mouth and Throat**
__ __ Concussions
__ __ Glasses
__ __ Eye Strain
__ __ Red eyes
__ __ Dry eyes
__ __ Itchy eyes
__ __ Excessive tearing
__ __ Poor/ Blurry vision
__ __ Night blindness
__ __ Spots in vision
__ __ Earaches/ Infections
__ __ Ringing in ears
__ __ Poor hearing
__ __ Sinus congestion
__ __ Post-nasal drip

Now Past **HEENMT (cont.)**
__ __ Excessive phlegm
Color: _____
__ __ Frequent sneezing
__ __ Dry nose
__ __ Nose bleeds
__ __ Dry mouth
__ __ Bad breath
__ __ Bleeding, swollen, or painful gums
__ __ Canker sores
__ __ Sores on tip of tongue
__ __ Strange taste in mouth: _____
__ __ Recurrent sore throat
__ __ Swollen glands
__ __ Feeling of pit/ lump in throat

__ __ Migraines
Location: _____
Triggers: _____
Severity (1-10)____/10
__ __ Headaches
Location: _____
Triggers: _____
Severity (1-10) ____/10

Now Past **Respiratory**
__ __ Difficulty breathing when lying down
__ __ Shortness of Breath
__ __ Tight Chest
__ __ Wheezing
__ __ Easily catch cold
__ __ Allergies
__ __ Cough
☐Wet ☐Dry
☐Thick ☐Thin
Color of Phlegm: _____
Blood? _____
__ __ Other:_____

Now Past **Cardiovascular**
__ __ High blood pressure
__ __ Low blood pressure
__ __ Chest pain/ tightness
__ __ Palpitations
__ __ Fainting
__ __ Dizzy/ Weak on standing
__ __ Swelling of feet, ankles, legs
__ __ Swelling of hands
__ __ Blood clots
__ __ Phlebitis
__ __ Other: _____

Now Past **Gastrointestinal**
__ __ Nausea
__ __ Vomiting
__ __ Gagging/ Difficult swallowing
__ __ Hiccups
__ __ Belching
__ __ Acid Regurgitation
__ __ Abdominal Pain/ tenderness
__ __ Feeling Tired or heaviness after eating
__ __ Diarrhea
__ __ Constipation
__ __ Gas/ Bloating
__ __ Alternating Diarrhea and Constipation
__ __ Chronic Laxative use
__ __ Blood in stools
__ __ Black stools
__ __ Mucus in Stools

__ __ Itchy anus
__ __ Burning anus
__ __ Hemorrhoids/ fissures
__ __ Undigested food in stool
Bowel Movement
Frequency _____
Texture_____
Other concerns with digestion:
_____

Now Past **Urinary**
__ __ Painful urination
__ __ Frequent urination
__ __ Blood in urine
__ __ Cloudy urine
__ __ Urgency to urinate
__ __ Incontinence
__ __ Wake to urinate
__ __ Incomplete urination or Dribbling
__ __ Kidney infections
__ __ Kidney stones
__ __ Bedwetting

Now Past **Men Only**
__ __ Prostate problems
__ __ Testicular pain/ swelling
__ __ Decreased/ low sexual desire
__ __ Increased/ high sexual desire
__ __ Painful intercourse
__ __ Impotence
__ __ Sexually-transmitted disease
__ __ Premature ejaculation
__ __ Nocturnal emissions
__ __ Other: _____

Women Only
Are you pregnant now? _____
Trimester: _____
Are you trying to get pregnant?_____
First date of last menses_____
Length between menses_____
Duration of period _____
Do you use birth control? □Y □N
Method: _____
Age at first period _____
Age at menopause _____
# of Pregnancies _____
# of Births _____
# of Abortions _____
# of Miscarriages _____
Complications with any births? _____
_____
_____
Hysterectomy? □Y □N

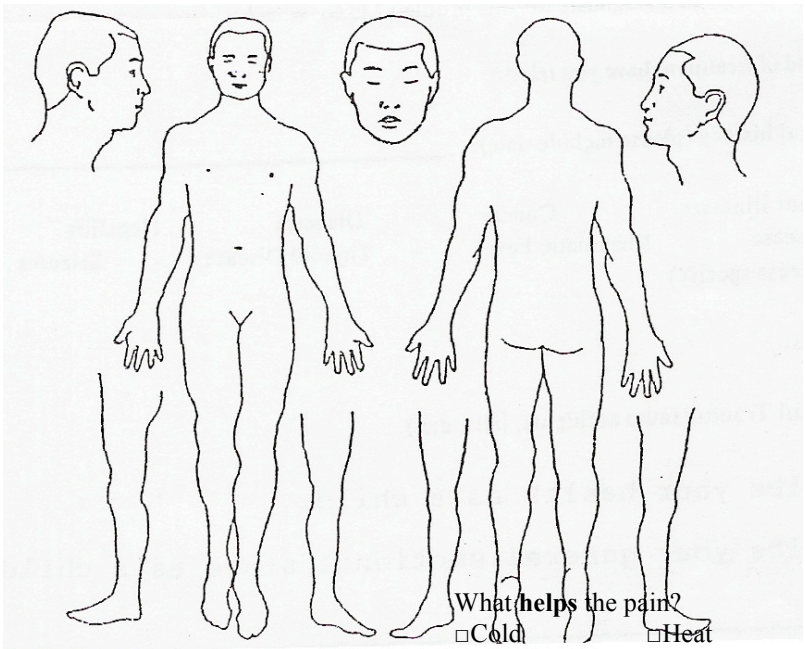
Now Past **Gynecology**

Abigail Thomas Costello MS, LAc, LMT
Initial Evaluation

309 N. Tioga Street
Ithaca, NY 14850
607-274-7520

__ __ Irregular periods
__ __ Painful periods
__ __ Mood changes
__ __ Water retention
__ __ Scanty flow
__ __ Heavy flow
__ __ Bleeding between cycles
__ __ Clotting Color _____
__ __ Painful or swollen breasts
__ __ Breast lumps
__ __ Nipple discharge
__ __ Pain during intercourse
__ __ Itching, pain or discomfort in genital area
__ __ Chronic yeast infections
__ __ Sexually Transmitted disease
__ __ Abnormal PAP smear
Date: _____
__ __ Vaginal discharge
Color:_____
__ __ Vaginal dryness
__ __ Vaginal odor
__ __ Uterine fibroids
__ __ Endometriosis
__ __ Ovarian cysts
__ __ Inability to conceive
__ __ Hot flashes
__ __ Menopausal symptoms
__ __ Decreased/ low sexual desire
__ __ Increased/ high sexual desire

Now Past **Musculo-skeletal**
(Indicate location on chart below)
__ __ Muscle pain or stiffness
__ __ Swollen/painful/stiff joints
__ __ Muscle spasm/cramps
__ __ Tremors or twitches
__ __ Loss of strength
__ __ Muscle wasting
__ __ Sprains/ Strains
__ __ Tendonitis
__ __ Bursitis
__ __ Broken bones
__ __ Stiff neck/ shoulders
__ __ Arm/ Elbow/ hand pain
__ __ Leg/ Knee/ Ankle pain
__ __ Upper back pain
__ __ Mid-back pain
__ __ Low back pain
__ __ Head injuries
__ __ Joint replacements
Which & When_____



3. Pain Evaluation
Onset of Pain:
□Sudden □Gradual
□Injury □Disease
□Unknown
Quality of Pain:
□Dull □Sharp
□Sore □Stabbing
□Cramping □Burning
□Fixed □Moving
□Constant □Intermittent
Does it **radiate**? _____

Now Past **Neurological**
__ __ Numbness / Tingling
__ __ Paralysis
__ __ Bell's Palsy
__ __ Loss of Balance
__ __ Lack of coordination
__ __ Other: _____

Now Past **Psychological/ Mental**
__ __ Depression
__ __ Anxiety
__ __ Mood swings
__ __ Irritability
__ __ Easily confused
__ __ Dementia
__ __ Mental sluggishness
__ __ Memory problems
__ __ Emotional/ Physical abuse
__ __ Treatment by a therapist
Date: _____
__ __ Consider/ attempt suicide

What **helps** the pain?
□Cold □Heat
□Rest □Movement
□Pressure □Massage
□Nothing □Other

What **aggravates** the pain?
□Cold □Heat
□Rest □Movement
□Pressure □Massage
□Nothing □Other

Abigail Thomas Costello MS, LAc, LMT
Initial Evaluation

309 N. Tioga Street
Ithaca, NY 14850
607-274-7520

IV. Personal Habits and Lifestyle

1. Substance use

Tobacco pack/day_____
Alcohol drinks/wk_____
Coffee/tea/cola cups/day_____
Recreational drugs times/wk_____

2. Work Activity

Sitting % of time_____
Standing % of time_____
Light labor % of time_____
Heavy labor % of time_____

3. Exercise

Do you exercise regularly? □Yes □No
Describe what you do and how often?

_____

4. Stress Level

On a scale of **1** (low) to **10** (high), indicate level of stress you feel about the following:

Family___ Significant other ___ Personal life ___
Work___ Academic___ Life changes ___

5. Diet

Sample Daily Menu

Morning	Noon	Evening
_____	_____	_____
_____	_____	_____
_____	_____	_____
Snack:	Snack	Snack
_____	_____	_____

How would you describe your dietary preferences?

□ Vegetarian □ Vegan □ Standard American Diet(meat, potatoes, vegetables, bread)
□ Low-Fat □ Fast Food □ Mostly restaurant □ Low Carbohydrate, High protein

Please list all medications you are currently taking (or have used in the past two months) with dosages

Drug	Reason	Start date	Dosage
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

Please list any vitamins, minerals, herbs or homeopathic remedies that you are taking

Supplement	Reason	Start date	Dosage
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

Please list all allergies you have to

Drugs	Foods	Other (pollen, dust, etc.)
_____	_____	_____
_____	_____	_____

Please list any surgeries that you have had.

Diagnosis	Surgical Procedure	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account, and that payment is expected at the time of service. I also understand and accept that I am expected to notify the office 24 hours prior to any cancellations or changes to my appointment time, and that successive late cancellations or missed appointments may result in a charge being placed on my account.

X Signed: _____ Date: _____