



6 Green Hill Road
 Washington Depot CT
 860.619.2788
 info@valleyspiritcoop.com
 www.valleyspiritcoop.com

Patient Health Update Form

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. Thank you.

Name: _____ Today's Date: _____

Today's main health concern is: _____

New symptoms or health concerns since last session: _____

Please rate yourself in each of the following areas. Be as specific as you can for how you are today. Remember, the more thorough you are, the better we can help you, and the faster we can get results!

Energy Level	1	2	3	4	5	6	7	8	9	10
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Sleep (Fall asleep easily, trouble sleeping? Waking up rested? Sleeping without waking to urinate? Etc.)

Digestive Function (Gas, bloating, abdominal distention, food stagnation, acid reflux, heartburn, or nausea/vomiting.)

Hunger & Thirst (Weak appetite for breakfast? Strong thirst? Etc.)

Bowel Movement (Frequency, regularity, texture or shape of stools, color and odor.)

Urination (Frequency, urgency, dribbling after completion, difficulty initiating, cloudy, or dark urine?)

Pain (This includes muscular and internal pains, numbness, spasms, and cramping.)

For Women Only Today is the _____ day of my menstrual cycle.

(Check One) I am am not tracking my ovulation. Have you menstruated since last session? yes no

Any clotting? yes no How much did you bleed during menstruation? Heavy Moderate Light

Do you have pain during menstruation? yes no The pain / cramping is: Mild Moderate Severe

Did you experience PMS? Emotional instability? yes no Breast tenderness? yes no

Abdominal bloating? yes no Change in bowel movements? yes no Headaches? yes no

Other: _____

NOTES:

For Doctor's use only:

Tongue Color: _____ Areas of color: _____

Shape: _____ Areas of color: _____

Pulse

Left: UJ: _____ MJ: _____ IJ: _____

Right: UJ: _____ MJ: _____ IJ: _____

Palpation Reactive Points and Meridian Regions: _____

TCM Diagnosis _____

Treatment Plan _____

Acupuncture Point Prescription

Herbal Prescription # of Bags _____ Filled by: _____

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Notes:

Acupuncturist's Signature _____ **Date** _____