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Five Element Acupuncture and Traditional Chinese Medicine

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This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Personal Information

Your personal information will be kept personal. We will use the following information to contact you only with your permission.

Name_____ Birth date _____ Today's Date _____

Preferred Pronouns: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other _____

Home Address_____

City_____ State_____ Zip_____

Phone #_____May I leave a message at this number? Y N Can I send texts to this number? Y N

e-mail address _____

How did you hear about me? Referred by:_____ ☐ Google ☐ Yahoo ☐ Yelp ☐ Other

If the patient is a minor, please list legal guardian responsible for this account _____

Contact information for legal guardian: _____

Emergency Contact: Name_____ Phone: _____

Have you had acupuncture treatments before? Yes No

Please list any prescription or over-the-counter medications you are presently taking:

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If your medications do not fit on this page, check this box ☐ and continue on the back.

Missed Appointment Policy

A missed appointment is a loss to everyone. If you need to cancel an appointment please try to give me 48 hours' notice so I can fill your spot. If you cancel, or miss, an appointment with less than 24 hours' notice you may be charged the full price of the scheduled appointment. _____ (please initial)

Chief Complaint

Please list 1 to 5 intentions or concerns that you would like to address. Place them in the order of priority.

1 _____

2_____

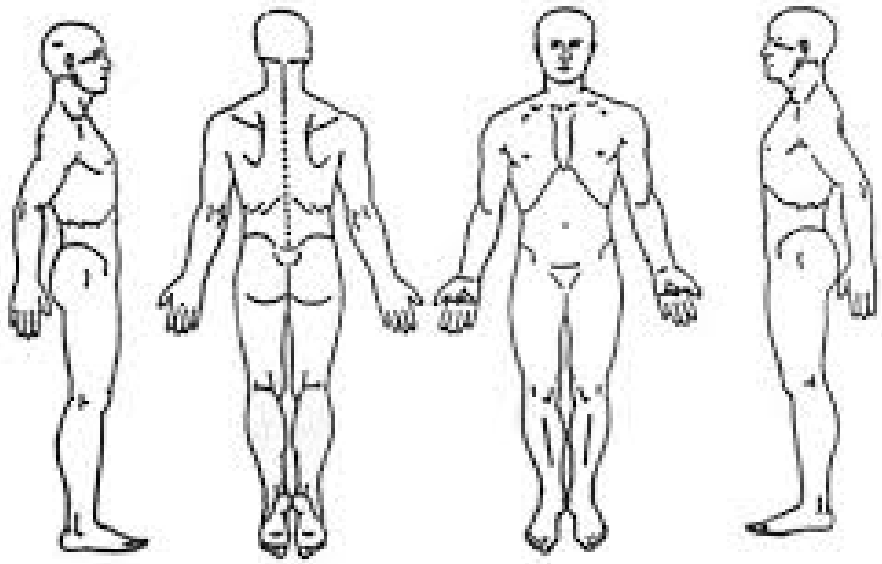
3_____

4_____

5_____

Please mark all of the areas in your body where you feel pain or discomfort regularly or presently:
mark the area with the following symbol to indicate the type of pain:

○ dull/achy X sharp/stabbing △ burning □ tingling/ numbness/electrical



Diet

Do you have any diet restrictions or preferences? (ie: gluten free, vegetarian, paleo) _____

_____

What do you typically eat for breakfast?_____

_____

What do you typically eat for lunch?_____

_____

What do you typically eat for dinner? _____

_____

Do you eat between meals and/or desserts regularly? If yes, what is typical? _____

_____

Confidential Health History

Patient Name: Date:

Family Medical History

Please check the box corresponding to the family member(s) that have/had the following health conditions

Y=Yourself F=Father M=Mother S=Siblings O= Other (Grandparents, Aunts and Uncles)

Y	F	M	S	O	High Blood Pressure	Y	F	M	S	O	Any Cancer	Y	F	M	S	O	Migraines
Y	F	M	S	O	Heart Disease	Y	F	M	S	O	Any Hepatitis	Y	F	M	S	O	Depression
Y	F	M	S	O	Stroke	Y	F	M	S	O	HIV/AIDS	Y	F	M	S	O	Anxiety
Y	F	M	S	O	High Cholesterol	Y	F	M	S	O	Seizures	Y	F	M	S	O	Suicidal thoughts
Y	F	M	S	O	Pacemaker	Y	F	M	S	O	Autoimmunity	Y	F	M	S	O	ADD/ADHD
Y	F	M	S	O	Diabetes	Y	F	M	S	O	Thyroid problems	Y	F	M	S	O	Bipolar Disorder
Y	F	M	S	O	Obesity	Y	F	M	S	O	TMJ dysfunction	Y	F	M	S	O	Addiction Issues

Medical History

Are you pregnant? Yes No Are you trying to become pregnant? Yes No

List any hospitalizations with date and reason:

List any major or chronic health incidents, including accidents:

List any allergies:

Habits (circle one)

How frequently do you exercise?	Daily	Weekly	Rarely	Never
How frequently do you get 8 hours of sleep?	Daily	Weekly	Rarely	Never
How frequently do you meditate?	Daily	Weekly	Rarely	Never
How frequently do you drink alcohol?	Daily	Weekly	Rarely	Never
How frequently do you use marijuana?	Daily	Weekly	Rarely	Never
How frequently do you use other recreational drugs?	Daily	Weekly	Rarely	Never
How frequently do you use tobacco products?	Daily	Weekly	Rarely	Never
How frequently do you ingest refined sugar?	Daily	Weekly	Rarely	Never