true vitality
ACUPUNCTURE, LLC
classical five-element

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Client Information

Please read, complete, and bring with you to your initial consultation. All information is confidential.

Name:_____ Age: _____ Date of Birth: _____

Street Address: _____ Gender: M / F

Phone numbers: _____ Email address:_____

Emergency contact: _____Relationship:_____

Phone number: _____ Address:_____

Current Medical Doctor: _____ Specialty: _____

Address:_____ Phone number: _____

Date of most recent complete medical exam: _____ Most recent blood work:_____

Are you allergic to any medications? _____

What are you seeking treatment for today? _____

What are your most important health concerns: Please list in order of importance:

1._____ Date of onset:_____

2._____ Date of onset: _____

3. _____ Date of onset: _____

Medications/ Vitamins/ Herbal Supplements:

Name	Dose	Reason for taking	Date began taking

How did you hear of me? May I thank someone for referring you? _____

_____ Please initial here to indicate I have permission to discuss your case with your health care provider,

_____ (health care provider name here.)

During your initial consultation, we will cover medical illnesses, hospitalizations, surgeries, gynecological health, mental/emotional health, and health maintenance (immunizations and screening tests.) Please come prepared to discuss these topics. Thank you!

Medical History. (Childhood and adult illnesses, accidents, surgeries. Approximate years.)

Family Medical History. (Specific conditions, hereditary issues, causes of death)

Energy Level. (Select on a scale of 1-10. 10 being spectacular, where are you today? Where would you like to be?)

Exercise and hobbies. (What do you enjoy doing? What type and how often do you exercise?)

Stress. (Sources of stress in your life.)

Sleep. (How many hours/day? Is it restful? Any issues/difficulties around sleep?)

Smoking. (Do you or have you ever? How much? How long?)

Digestion. (Typical meals in a day. Any food allergies? Digestive problems?)

Fluids. (What do you drink? Water, coffee, alcohol. How much/day?)

Respiratory. (Breathing difficulties? Sinus issues? Headaches?)

Cardiovascular. (Blood Pressure, palpitations, hot/cold hands/feet.)

_____

_____

Elimination. Urinary. (frequency, pain) _____

Bowel Movements. (Frequency. Regular? Constipation or Diarrhea issues?)

_____

_____

Reproductive System. (Pregnancies- How many? How was it? Difficulties?)_____

_____

(Menstruation- Regularity? How is it? Duration? Frequency? Flow? PMS issues?) _____

_____

_____

_____

Musculoskeletal. (Muscles, bones, joints, aches/pains, mobility. **Please draw below.)_____

_____

_____

Nervous System. (Numbness, tingling, pins and needles. Migraines. **Please draw below.) _____

_____

_____

(Types of pain you experience: pain, ache, sharp, stabbing, sting, zingers ,burning, stiff, other.) Please circle.