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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 __________

Home Address____

City____ State_______________ Zip__________

Best Phone #________________________ May I leave a message at this number ? Y N Can I text to this number? Y N

2nd Best Phone #_____________________ May I leave a message at this number ? Y N Can I text to this number? Y N

e-mail address ______________________________

May I have your permission to send the following e-mails to this address?

Appointment confirmation and reminders? Y N

Holiday, Birthday and Thank you for your referral cards? Y N

Promotional coupons, discounted services, invitations to events in this office? Y N

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 therapy before? Yes No With Whom? ______________________________

Have you had a professional massage before? Yes No Approximately how many times? 1 2 3 4 5 6+

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.

Chief Complaint

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

1 ______________________________

2______________________________

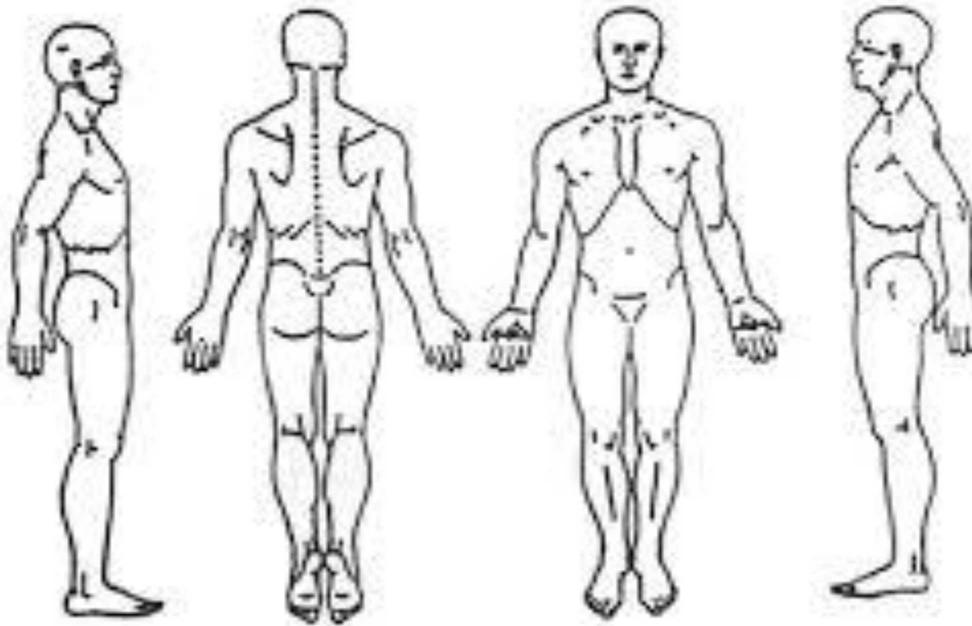
3______________________________

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 Δ 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	Condition	Y	F	M	S	O	Condition	Y	F	M	S	O	Condition
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)

Question				
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

Disclosures

Missed Appointment Policy

A missed appointment is a loss to everyone. If you need to cancel an appointment please 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)

Please read the PDF of all three disclosures (also on the website) and sign below on this sheet to acknowledge that you have read and understand the information provided in each document.

Informed Consent for acupuncture treatment and care

This document contains important information about the risks and benefits of acupuncture and related therapies. It outlines your right to be informed about any and all treatment you receive, as well as your right to refuse any treatment. Your responsibilities as a patient are also described. Please read the entire document and sign below to acknowledge that you have read and understand the Informed Consent document.

Please Print Patient's Name

Print Guardian's Name (if applicable)

Patient or Guardian's Signature

Date

HIPPA Regulations

The information provided in this document illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Please read the entire document and sign below to acknowledge that you have read and understand the HIPPA regulations.

Please Print Patient's Name

Print Guardian's Name (if applicable)

Patient or Guardian's Signature

Date

Department of Regulatory Agencies Disclosure

This Document includes information including fee schedule, patient rights, and licensing as well as information on how to lodge a formal complaint against a licensed professional. Please read the entire document and sign below to acknowledge that you have read and understand the Department of Regulatory Agencies Disclosure.

Please Print Patient's Name

Print Guardian's Name (if applicable)

Patient or Guardian's Signature

Date