Elephant Acupuncture

512-779-8296

Personal Information

Name: ____ Date: _______________

Date of birth: ____________________ Age: ________ Gender: ____________________

Street Address: ____

City: ___________________________ State: _______ Zip Code: __________________

Main Phone: _______________________________ Text Message Allowed? __________

Emergency Contact & Phone: ____

E-mail Address: _____________________________ Email Contact Allowed? _________

Would you like to receive Elephant Acupuncture's monthly newsletter? ______________

Have you ever been treated with acupuncture before? _____________________________

Have you ever taken Chinese Herbs? pills/tincture/powder/raw? ___________________

How did you hear about Elephant Acupuncture? __________________________________

____

Name: ____ Date: _______________

Reason for Visit

Chief Complaint: ____

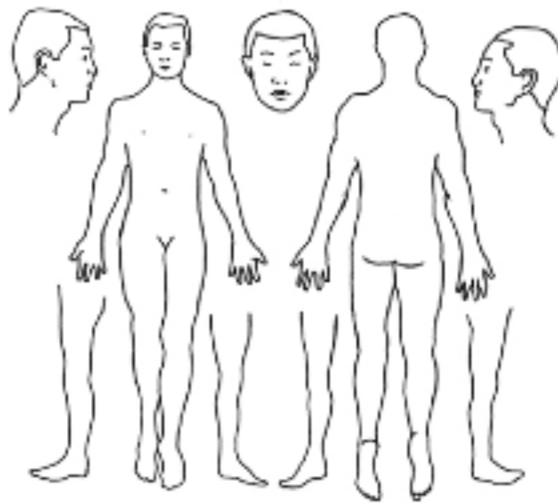
When did this begin? _________________Known cause? _____________________

What kind of treatment have you tried? ___________________________________

What worsens your condition? ____

What improves your condition? ____

Please circle the areas of concern/pain:



Please circle the sensations/pain characteristics:

Sharp - Burning - Moving - Tingling - Dull - Severe - Stabbing - Shooting - Throbbing

Numbness - Muscle pain - Joint pain - Constant - Intermittent

Pain level 1-10: ______ Worse during the day or at night? ______________________

Comments: ____

Name: ____ Date: ____________

Medical History

Please mark all that apply - P (past) C (current) F (family):

_____ Alcoholism/Addictions	_____ Epilepsy	_____ Multiple Sclerosis
_____ Allergies	_____ Hemophilia	_____ Rheumatic Fever
_____ Anemia	_____ Headaches/migraines	_____ Seizures
_____ Arthritis	_____ Heart conditions	_____ Spinal or head injury
_____ Autoimmune Disorder	_____ Hepatitis	_____ Sprain/Strain/Fracture
_____ Cancer	_____ High blood pressure	_____ STD's
_____ Deep vein thrombosis	_____ HIV/AIDS	_____ Stroke
_____ Depression or anxiety	_____ Irritable Bowel Syndrome	_____ Thyroid disease
_____ Diabetes	_____ Kidney disorder	_____ Upcoming Surgeries
_____ Dizziness/fainting	_____ Lupus	_____ Wear a pacemaker

Please list:

Significant trauma(s): ____

____

____

Surgeries: ____

____

____

Allergies: ____

____

____

Name: ____ Date: _______________

Please list all herbs/supplements and medications you are currently using:

Herbs/supplements	Used for	Herbs/supplements	Used for
1		4	
2		5	
3		6	

Prescription medication	Used to treat	Prescription medication	Used to treat
1		4	
2		5	
3		6	

Women Only:

Number of pregnancies: _________________Number of live births: __________________

Average # of days of your entire menstrual cycle: _________ of menstruation: ________

Describe your flow (heavy/light/average/dark/bright/with clots/rusty brown/etc): ______

____

Do you have any of the following issues before, during or after your menstrual flow?

_____ Back ache	_____ Constipation	_____ Headaches	_____ Nausea / vomiting
_____ Breast tenderness	_____ Cramps	_____ Irritability	_____ Night sweating
_____ Breast lumps	_____ Depression	_____ Insomnia	_____ Water retention
_____ Bloating	_____ Diarrhea	_____ Migraines	Other:

Age of menopause if applicable: ____

Name: ____ Date: _____________

Lifestyle

Do you have a regular exercise program? Please describe: _______________________

____

How many hours a night do you sleep? __________ Do you wake rested? __________

How often do you use nicotine? ____________ Recreational drugs? _______________

Do you have a regular spiritual practice? Please describe: _______________________

____

Describe your typical diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Percentage of your diet cooked at home? _______ fresh produce? _____ meat? _____

How much water do you drink daily? ________ caffeine? ______ alcohol? ________

Please list your dietary restrictions: ____

____

Please list your dietary sensitivities/allergies: ____________________________________

____

Please list any foods that lower your energy or digestive functioning: _______________

____

I have completed this form correctly to the best of my knowledge.

Signature/date: ____