Five Element Acupuncture
Homer LLC

General Information

Please fill out the questions below as thoroughly as you can.

What are you looking for help with?
When did it begin? Does anything make it better or worse?
Are you currently under the care of any other healthcare providers? (MD, therapists, specialists, etc.)
Please list all medications or supplements you are currently taking, including dosages and what each is for.
Is there anything you'd like me to know that you feel may be affecting your quality of life right now?

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Health History Questionnaire

Please check all conditions that reflect your past or present health.
Use line provided to add additional details.

Cardiovascular

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Attack When? _____
- ☐ Stroke When? _____
- ☐ Irregular Heartbeat/Palpitations

Respiratory

- ☐ Asthma
- ☐ Shortness of Breath
- ☐ COPD/Emphysema
- ☐ Chronic Cough

Digestive

- ☐ Acid Reflux/GERD
- ☐ Gas/Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Crohn's/Colitis
- ☐ IBS

Neurological

- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness/Vertigo
- ☐ Tremors Type _____ Location_____
- ☐ Seizures
- ☐ Numbness/Tingling Location _____

Mental/Emotional

- ☐ Anxiety/Panic Attacks
- ☐ Depression
- ☐ Major Loss
- ☐ Disordered Eating
- ☐ History of Trauma/PTSD/CPTSD
- ☐ Addiction/Substance Abuse
- ☐ Suicidal Ideation/Self Harm
- ☐ Hallucinations/Delusions/Paranoia

Metabolic/Endocrine

- ☐ Hyperthyroidism/Graves'
- ☐ Hypothyroidism/Hashimoto's
- ☐ Diabetes Type 1 _____ Type 2_____
- ☐ Other _____

Immune/Autoimmune

- ☐ Frequent Colds/Infections
- ☐ Food Allergies/Sensitivities
- ☐ Lupus
- ☐ Rheumatoid/Psoriatic Arthritis
- ☐ Multiple Sclerosis
- ☐ Other _____

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Reproductive

- ☐ Painful Periods
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ Endometriosis
- ☐ Ovarian Cysts/PCOS
- ☐ Low Libido
- ☐ Fertility Issues/Trouble Conceiving
- ☐ PMS/PMDD
- ☐ Pregnancy Loss Type _____How many____
- ☐ Menopause Last Period _____
- ☐ Erectile Dysfunction
- ☐ Impotence

Musculoskeletal

☐ Joint Pain/Arthritis

☐ Muscle Pain/Tension

When _____

Where _____

Quality _____

☐ Injuries/Fractures

☐ Generalized Pain

When _____

Where _____

Quality _____

Sleep

- ☐ Difficulty Falling Asleep
- ☐ Frequent Waking
- ☐ Snoring/Sleep Apnea
- ☐ Nightmares/Vivid Dreams
- ☐ Night Sweats
- ☐ Daytime Sleepiness/Fatigue

Rate the following from 0-10

Energy: 0 1 2 3 4 5 6 7 8 9 10

Stress: 0 1 2 3 4 5 6 7 8 9 10

Additional Information

- ☐ Ear/Hearing Issues
- ☐ Eye/Vision Issues
- ☐ Kidney Issues/Stones
- ☐ Bladder Issues
- ☐ Sweating Issues
- ☐ Swelling/Edema
- ☐ Eczema/Psoriasis
- ☐ Acne/Boils

History of Cancer (Type, Year, Treatment)_____

_____

Major Surgeries (What, Year, Reason)_____

_____

Other Medical Diagnoses/Health History (physical & mental)_____

_____