

Five Elephants Acupuncture

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**Health History**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_

Emergency Contact (name & number)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the main health concerns you would like to address in order of importance:

Surgeries, Major Illnesses, Hospitalizations, and Major Accidents:

Current medications, supplements, and vitamins (including what they are for):

Sleep: Hours per night\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time to Bed\_\_\_\_\_\_\_\_\_\_\_\_ Time to Rise\_\_\_\_\_\_\_\_\_\_\_\_\_

Feel Rested in AM? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Trouble Falling Asleep? Yes No Sometimes

Wake during the night? Yes No Vivid Dreaming? Yes No

Digestion: Good Appetite? Yes No Cravings for certain foods?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you normally eat?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bowel Movement Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Feels Complete? Yes No Consistency: Well-Formed Hard Loose Alternates day to day

Undigested Food Blood Mucus

Urination: Burning Urgent Retention Frequent Scanty Profuse Dribbling

Cloudy Dark Pale Any Edema (swelling of limbs)

Immunity: Frequent Colds Allergies History of Respiratory Infection Frequent Antibiotic Use

How is your Energy Level? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stress Level?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: What do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Enjoy work? Yes No

Hours per week working \_\_\_\_\_\_\_\_\_\_\_

Libido: Too low Just right Too high Any complications with sexual functioning?

Are you thirsty often? Yes No If so do you crave warm or cold drinks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you find that you “run” particularly hot or cold?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you often get headaches or migraines? Yes No Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dull/Stabbing

Body Pain? Where and how long?

Anything else you would like us to know?

(For Women)

Menstruation: Long/Short/Irregular Cycles Painful Menses Clots/Heavy Bleeding Scanty Bleeding

Breast Tenderness Bleeding Between Cycles Profuse Discharge Birth Control Pills? (now/past)

Abortion or Birth Complications?

Thank you! Successful health care and preventive medicine are most effective when the practitioner has a complete understanding of what is going on physically, mentally, and emotionally. You will have time to discuss in more detail with your practitioner. Enjoy your treatment.