

FIVE ELEMENTS TCM

ST.GALLEN



Name _____

Address _____

Day time phone _____ E-mail address _____

Eve phone _____ cell _____

How did you hear about Five Elements _____

Date of birth _____ Height and weight _____

Doctor's name and address _____

Do I have permission to contact your doctor? no _____ yes _____ initial _____

Medication list _____

Supplement list _____

Primary Complaint _____

Duration of complaint _____

Do you have other symptoms you'd like to address? _____

What makes your symptoms better or worse? _____

Signed and Dated

On a scale of 1 to 10, how would you rate your energy?

How many times a year do you get a cold or flu?

Is your blood pressure high or low? (If you get dizzy when you get up suddenly, it's often low)

Do you crave sweets?

Do you have any scars or operations that might cause internal scarring?

Do you have back, hip, or knee pain that gets worse with fatigue?

Night-time urination?

Burning urination?

Are your symptoms worse with stress or before your period?

Do you have floaters in your eyes or blurry vision or poor night vision?

Do you have tremors, dizziness, or tics?

Do you have a bowel movement daily?

Women: Days between menstrual cycle?

Duration of bleeding?

Heavy bleeding and/or pain?