Jenny Dull L.Ac.

Elements of Health

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Name	Today's Date	
HOME Phone	CELL Phone	*Text appt reminders? Y / N*
Email	Date of Birth	
Address	City	Zip
Referred By		
Emergency Contact Name	Relationship	Phone
Occupation	Employer	
Primary Care Physician Name	Date of Last Physical Exam	
Other Practioners		
Have you had Traditional Chinese Medicine therapies in the past? NO YES, With whom?		

MAJOR COMPLAINT, INJURY OR ILLNESS

Describe when your injury or symptoms began

List all medications & supplements taken in the last two months