RAMONA
TAMIYASU
M.AC., L.Ac.

CLIENT PROFILE

Date

Last Name | First Name
Address | Apt./Suite
City | State | Zip
Phone

Birthdate | Height | Weight
Medical Doctor | Phone

Please select a level for any condition that you experience;
1 — sometimes experience, 2 — occurs often, 3 — major concern

Water

1	2	3	
○	○	○	hearing loss
○	○	○	dizziness
○	○	○	lower backache/neck pain
○	○	○	sinus congestion
○	○	○	edema
○	○	○	darkness under eyes
○	○	○	emotional instability
○	○	○	aversion to cold
○	○	○	hair thinning or loss
○	○	○	premature aging
○	○	○	frequent urination
○	○	○	kidney stones
○	○	○	perspire easily
○	○	○	weakness of knees/legs
○	○	○	asthmatic cough
○	○	○	rapid weight change
○	○	○	loose teeth
○	○	○	reduced sexual energy
○	○	○	thyroid problems
○	○	○	diabetes

Earth

1	2	3	
○	○	○	indigestion
○	○	○	flatulence
○	○	○	food allergy
○	○	○	stomach ache/ulcer
○	○	○	diarrhea
○	○	○	anemia
○	○	○	halitosis (bad breath)
○	○	○	sores in mouth
○	○	○	heartburn
○	○	○	strong appetite
○	○	○	weak appetite
○	○	○	nausea
○	○	○	abdominal bloating
○	○	○	low body weight

Wood

1	2	3	
○	○	○	headaches
○	○	○	migraines
○	○	○	ringing in ears
○	○	○	poor eyesight
○	○	○	eye infections
○	○	○	dry eyes
○	○	○	eczema
○	○	○	shingles
○	○	○	herpes simplex
○	○	○	warts
○	○	○	nervousness
○	○	○	convulsion/spasms
○	○	○	irritability
○	○	○	constipation
○	○	○	hemorrhoids
○	○	○	hepatitis
○	○	○	ulcer
○	○	○	vomiting
○	○	○	gallstones
○	○	○	indecisive
○	○	○	fullness below ribs
○	○	○	shoulder/neck tension
○	○	○	insomnia (11pm-3am)

Metal

1	2	3	
○	○	○	bronchitis
○	○	○	asthma
○	○	○	shallow breathing
○	○	○	cough
○	○	○	sinus congestion
○	○	○	nasal infections

Fire

1	2	3	
○	○	○	dry scalp
○	○	○	skin eruptions/rash
○	○	○	cysts/tumors
○	○	○	ear infections
○	○	○	sore throat/tonsilitis
○	○	○	lymphatic swelling
○	○	○	hot palms/soles of feet
○	○	○	heart palpitations
○	○	○	aversion to heat
○	○	○	bitter taste in mouth
○	○	○	gum problems
○	○	○	nose bleeds
○	○	○	facial redness
○	○	○	itching/burning skin
○	○	○	hot hands/feet
○	○	○	thirst
○	○	○	vivid dreaming
○	○	○	dark urine
○	○	○	night sweats

Other

1	2	3	
○	○	○	fatigue
○	○	○	arthralgia
○	○	○	sciatica/nerve pain
○	○	○	cold hands/feet
○	○	○	tendonitis
○	○	○	bursitis

CLIENT PROFILE
(continued)

Last Name _____ First Name _____

1	2	3	Female Clients
○	○	○	PMS (pre-menstrual syndrome)
○	○	○	infertility
○	○	○	excessive bleeding
○	○	○	menstrual cramping
○	○	○	irregular periods
○	○	○	ovarian cysts
○	○	○	UTI (urinary tract infections)
○	○	○	intermittent periods
	☐		number of births

1	2	3	Male Clients
○	○	○	prostatitis
○	○	○	nocturnal emission
○	○	○	burning urination
○	○	○	incontinence
○	○	○	impotence

Medications/Supplements

Please describe your current fitness program

Please list what you eat and drink in a typical day: breakfast, lunch, dinner, snacks, drinks

Please indicate your level of physical pain, with 10 being the most intense

1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○

In what specific area(s) of the body is this occurring and how often?

Other Information

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