



Seattle Institute of Oriental Medicine

AN INNOVATIVE APPROACH TO ACUPUNCTURE AND ORIENTAL MEDICINE EDUCATION

HEALTH HISTORY QUESTIONNAIRE

TODAY'S DATE: _____

Primary Phone #

(home/work/cell)

Alternate Phone #

(home/work/cell)

Would you like to join our e-mail list to receive our newsletter with clinic updates and special offers? ___ YES ___ NO

(Our newsletter is a good way to stay informed of changes to our clinic schedule, dates of breaks, and special discounts and promotions. We send it infrequently, and we will not share your information with any third parties. You can unsubscribe easily at any time.)

How did you hear about us?

PCC Ad Internet friend postcard/flyer Other _____

First Name

Last Name

Nickname

Street Address

Birth Date

Age

Gender

City, State, Zip Code

Height

Weight

Email Address

Occupation

Emergency Contact

Relationship to Client

Emergency Contact's Phone #

Physician

Physician's Phone #

Referred By

How did you find out about us?

Have you been treated by acupuncture or oriental medicine before? YES NO

Have you had massage therapy or chiropractic treatment before? YES NO

Main problem(s) you would like to be treated for:
How long ago did this problem begin (please be specific)?
To what extent does this problem interfere with your daily activities?
Have you been given a diagnosis for this problem? If so, describe:
What kinds of treatment have you tried?

PAST MEDICAL HISTORY (please include dates)

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Rheumatic Fever _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Thyroid Disease _____
<input type="checkbox"/> Hepatitis _____	<input type="checkbox"/> Seizures _____
<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> STDs _____
<input type="checkbox"/> Other	
<input type="checkbox"/> Surgeries (type & date)	

<input type="checkbox"/> Significant Trauma (auto accidents, falls, etc.)	
<input type="checkbox"/> Significant Dental Work	
<input type="checkbox"/> Birth History	(Prolonged labor, c-section, etc.)
<input type="checkbox"/> Allergies	

FAMILY MEDICAL HISTORY

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Thyroid Disease _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Seizures _____
<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Stroke _____

Medications

Please include any taken within the last two months, including vitamins, herbs, etc.

<input type="checkbox"/> Occupational Stress	
<input type="checkbox"/> Regular exercise program	
<input type="checkbox"/> Restricted diet	
<input type="checkbox"/> Smoke	Number of cigarettes per day:
<input type="checkbox"/> Coffee/tea/soda	Number of servings per week:
<input type="checkbox"/> Alcohol	Number of servings per week:

<input type="checkbox"/> Non-medicinal drug use	
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Describe your average daily diet.

Morning	
Afternoon	
Evening	

PLEASE CHECK ANY SYMPTOMS YOU HAVE HAD IN THE PAST THREE MONTHS

GENERAL	SKIN AND HAIR	HEAD, EYES, EARS, NOSE, THROAT
<input type="checkbox"/> Poor appetite <input type="checkbox"/> Fever <input type="checkbox"/> Sweat easily <input type="checkbox"/> Localized weakness <input type="checkbox"/> Bleed or bruise easily <input type="checkbox"/> Peculiar taste or smells <input type="checkbox"/> Strong thirst (cold or hot) <input type="checkbox"/> Low thirst <input type="checkbox"/> Sudden energy drop What time of day? _____ <input type="checkbox"/> Poor sleeping <input type="checkbox"/> Chills or tremors <input type="checkbox"/> Poor balance <input type="checkbox"/> Fatigue <input type="checkbox"/> Night sweats <input type="checkbox"/> Cravings <input type="checkbox"/> Weight gain/loss	<input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Dandruff <input type="checkbox"/> Change in hair or skin <input type="checkbox"/> Ulcerations <input type="checkbox"/> Eczema <input type="checkbox"/> Hair loss <input type="checkbox"/> Hives <input type="checkbox"/> Acne <input type="checkbox"/> Recent moles <input type="checkbox"/> Other hair or skin problems _____	<input type="checkbox"/> Grinding teeth <input type="checkbox"/> Dental problems <input type="checkbox"/> Concussion <input type="checkbox"/> Eye strain <input type="checkbox"/> Night blindness <input type="checkbox"/> Blurry vision <input type="checkbox"/> Poor hearing <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Facial pain <input type="checkbox"/> Jaw clicks <input type="checkbox"/> Migraines <input type="checkbox"/> Eye pain <input type="checkbox"/> Color blindness <input type="checkbox"/> Earaches <input type="checkbox"/> Spots in eyes <input type="checkbox"/> Recurrent sore throat <input type="checkbox"/> Lip or tongue sores <input type="checkbox"/> Headaches <input type="checkbox"/> Other head or neck problems _____
	HEAD, EYES, EARS, NOSE, THROAT	
	<input type="checkbox"/> Dizziness <input type="checkbox"/> Glasses <input type="checkbox"/> Poor vision <input type="checkbox"/> Cataracts <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems	

CARDIOVASCULAR	GENITO-URINARY	NEUROPSYCHOLOGICAL
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Blood clots <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Dizziness <input type="checkbox"/> Swelling of hands or feet <input type="checkbox"/> Phlebitis <input type="checkbox"/> Chest pain <input type="checkbox"/> Fainting <input type="checkbox"/> Difficulty in breathing <input type="checkbox"/> Other heart or blood vessel problems	<input type="checkbox"/> Pain during urination <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> Decrease in flow <input type="checkbox"/> Frequent urination <input type="checkbox"/> Unable to hold urine <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones <input type="checkbox"/> Impotency <input type="checkbox"/> Genital sores <input type="checkbox"/> Other genital or urinary problems: _____ <input type="checkbox"/> Do you wake up to urinate? If so, how often? _____ <input type="checkbox"/> Any particular color to your urine: _____	<input type="checkbox"/> Seizures <input type="checkbox"/> Areas of numbness <input type="checkbox"/> Concussion <input type="checkbox"/> Bad temper <input type="checkbox"/> Dizziness <input type="checkbox"/> Lack of coordination <input type="checkbox"/> Depression <input type="checkbox"/> Easily susceptible to stress <input type="checkbox"/> Loss of balance <input type="checkbox"/> Poor memory <input type="checkbox"/> Anxiety <input type="checkbox"/> Other neurological or psychological problems _____
RESPIRATORY		
<input type="checkbox"/> Cough <input type="checkbox"/> Bronchitis <input type="checkbox"/> Difficulty in breathing when lying down <input type="checkbox"/> Production of phlegm What color? _____ <input type="checkbox"/> Coughing blood <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Pain while breathing deeply <input type="checkbox"/> Other lung problems: _____	PREGNANCY & GYNECOLOGY	
GASTROINTESTINAL	<input type="checkbox"/> Number of pregnancies _____ <input type="checkbox"/> Number of births _____ <input type="checkbox"/> Premature births _____ <input type="checkbox"/> Miscarriages _____ <input type="checkbox"/> Abortions _____ <input type="checkbox"/> Age at first menses _____ <input type="checkbox"/> # days between periods _____ <input type="checkbox"/> Duration _____ <input type="checkbox"/> First date of last period _____ <input type="checkbox"/> Unusual character _____ <input type="checkbox"/> Painful periods <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> PMS <input type="checkbox"/> Clots <input type="checkbox"/> Vaginal sores <input type="checkbox"/> Irregular periods <input type="checkbox"/> Last Pap _____ <input type="checkbox"/> Breast lumps <input type="checkbox"/> Birth control: _____	
<input type="checkbox"/> Nausea <input type="checkbox"/> Constipation <input type="checkbox"/> Black stools <input type="checkbox"/> Bad breath <input type="checkbox"/> Abdominal pain or cramps <input type="checkbox"/> Chronic laxative use <input type="checkbox"/> Vomiting <input type="checkbox"/> Gas <input type="checkbox"/> Blood in stools <input type="checkbox"/> Rectal pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Belching <input type="checkbox"/> Indigestion <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Other stomach or intestinal problems: _____	MUSCULOSKELETAL	
	<input type="checkbox"/> Neck pain <input type="checkbox"/> Back pain <input type="checkbox"/> Hand/wrist pain <input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Foot/ankle pain <input type="checkbox"/> Hip pain	

SIOM CLINIC POLICIES

The Seattle Institute of Oriental Medicine provides low cost, quality medical care in a teaching clinic setting. The following financial policy has been established to support the administration of the clinic and its mission.

Fees are due at the time of treatment. Current fees are available online at www.siom.edu/clinic. They are also posted at the clinic front desk.

Herbs vary in price and are not included in clinic treatment fees.

Our goal is to make acupuncture available to those who might not be able to afford it otherwise. We are not set up to file insurance claims or to accept delayed payments. We do not bill for services, and we ask for payment in full at the time of service. Payments must be by cash or check; we do not accept credit or debit cards.

In an effort to keep our costs low, and to avoid raising the costs of our treatments, we do not provide super-bills, fill out insurance forms, or respond to requests for records for insurance claims.

We do offer a limited reduced fee for those who are low-income, or are on Disability or Medicaid. Please ask at the front desk about these reduced fees.

SIOM prohibits the possession and use of all weapons, including but not limited to: firearms, knives, and mace, as well as noxious chemicals, fireworks and explosives.

We have limited clinic hours and there is often a waiting list. Therefore, we require 24 hours notice for changes or cancellations. **Appointments cancelled with less than 24 hours notice and appointments missed with no notification will be charged in full for that appointment.** Patients who qualify for a reduced fee will also be charged in full at the regular fee – not the reduced fee. Please pay for the missed visit at or before the next appointment. If you cancel two appointments with minimal or no notice, you will not be rescheduled until you have paid the cancellation fee for both visits. If there is a continued pattern of missed appointments, we may choose not to schedule you for appointments in the future. Please show our clinicians respect and plan ahead if you must cancel or change your appointment.

By signing this form, I am indicating that I understand and accept this policy.

Signature

Date

CONSENT FOR TRADITIONAL CHINESE MEDICINE

I, the undersigned, hereby authorize the student interns and/or clinical faculty of the Seattle Institute of Oriental Medicine to perform the following specific procedures:

Herbal prescriptions: May be given in the form of pills, powders, tinctures, pastes, plasters, or in raw form to be cooked. Cooked herbs may be given to take internally, or externally as a wash. **Herbal formulas may include shell, mineral, and animal products.**

If you do not want animal-based products used in your formula, please notify your practitioner at every visit when herbs are prescribed.

Acupuncture: Insertion of special sterilized needles through the skin into underlying tissues at specific points on the body. Because the needles are sterile and are only used one time, it is not necessary to swab the skin with alcohol prior to insertion; however, feel free to request this from your practitioner.

Tui-Na and Shiatsu: Forms of massage therapy that rely on specific hand techniques, pressure on acupuncture points, and isolated stretching. These techniques involve close physical contact, during which the practitioner may be on the treatment table with the patient.

If you are being treated in the tui-na or shiatsu clinics, please make sure that your student-practitioner is aware of any specific musculoskeletal complaints that you have or other medical conditions for which you have sought treatment.

Cupping: Cups made of glass, bamboo, or other materials are placed on the skin with a vacuum created by heat or other device. Some bruising may result.

Plum Blossom or Seven Star Hammer: Light tapping of an area of the body with a small sterile hammer which has seven points.

Gua Sha: Rubbing or scraping of an area of the body with a blunt, round instrument. Some bruising may result.

Moxibustion: Heating an acupoint using stick, string, or ball moxa to create a warming effect.

I RECOGNIZE THE POTENTIAL RISKS AND BENEFITS OF THESE PROCEDURES AS DESCRIBED BELOW:

Potential risks: Discomfort, pain, infection or blistering at the site of the procedure; temporary discoloration of skin; nausea; loose bowel movements; abdominal cramping; and aggravation of symptoms existing prior to the acupuncture treatment. Treatment may also result in other side effects.

Potential benefits: Drugless relief of presenting symptoms and improved balance of bodily energies, which can lead to prevention or elimination of the presenting problem and strengthen the constitution.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the Seattle Institute of Oriental Medicine, or any of its personnel, regarding cure or improvement of my condition.

I hereby release the Seattle Institute of Oriental Medicine and its practitioners from any and all liability which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Signature of patient or guardian

Date