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.)

First Name (Preferred) Last Name Preferred Pronoun

First Name (Legal, if different) Last Name Gender

Street Address Birth Date Age

City, State, Zip Code Height Weight

Email Address Occupation

Emergency Contact Relationship to Client Emergency Contact's Phone #

Physician Physician's Phone #

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)

☐ Cancer		☐ Rheumatic Fever	
☐ Diabetes		☐ Thyroid Disease	
☐ Hepatitis		☐ Seizures	
☐ High Blood Pressure		☐ STDs	

☐ Other	
☐ Surgeries (type & date)	

☐ Significant Trauma (auto accidents, falls, etc.)	
☐ Significant Dental Work	
☐ Birth History	(Prolonged labor, c-section, etc.)
☐ Allergies	

FAMILY MEDICAL HISTORY

☐ Cancer	_____	☐ Heart Disease	_____
☐ Diabetes	_____	☐ Thyroid Disease	_____
☐ Asthma	_____	☐ Seizures	_____
☐ High Blood Pressure	_____	☐ Stroke	_____

Medications

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

☐Occupational Stress	
☐ Regular exercise program	
☐ Restricted diet	
☐ Smoke	Number of cigarettes per day:
☐Coffee/tea/soda	Number of servings per week:
☐Alcohol	Number of servings per week:

☐ Non-medicinal drug use	

Describe your average daily diet.

Morning	
Afternoon	
Evening	

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

GENERAL

- ☐ Poor appetite
- ☐ Fever
- ☐ Sweat easily
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar taste or smells
- ☐ Strong thirst (cold or hot)
- ☐ Low thirst
- ☐ Sudden energy drop
  What time of day?_____
- ☐ Poor sleeping
- ☐ Chills or tremors
- ☐ Poor balance
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cravings
- ☐ Weight gain/loss

SKIN AND HAIR

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Hair loss
- ☐ Hives
- ☐ Acne
- ☐ Recent moles
- ☐ Other hair or skin problems

_____

HEAD, EYES, EARS,NOSE, THROAT

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems

HEAD, EYES, EARS, NOSE,THROAT

- ☐ Grinding teeth
- ☐ Dental problems
- ☐ Concussion
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in eyes
- ☐ Recurrent sore throat
- ☐ Lip or tongue sores
- ☐ Headaches
- ☐ Other head or neck problems

_____

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands or feet
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Difficulty in breathing
- ☐ Other heart or blood vessel problems

RESPIRATORY

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficulty in breathing when lying down
- ☐ Production of phlegm
  What color? _____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain while breathing deeply
- ☐ Other lung problems:

_____

GASTROINTESTINAL

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Other stomach or intestinal problems: _____

GENITO-URINARY

- ☐ Pain during urination
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Impotency
- ☐ Genital sores
- ☐ Other genital or urinary problems:

_____

- ☐ Do you wake up to urinate?
  If so, how often? _____
- ☐ Any particular color to your urine:

_____

PREGNANCY & GYNECOLOGY

- ☐ Number of pregnancies _____

- ☐ Number of births _____
- ☐ Premature births _____
- ☐ Miscarriages _____
- ☐ Abortions _____
- ☐ Age at first menses _____
- ☐ # days between periods _____
- ☐ Duration _____
- ☐ First date of last period _____
- ☐ Unusual character

_____

- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ PMS
- ☐ Clots
- ☐ Vaginal sores
- ☐ Irregular periods
- ☐ Last Pap _____
- ☐ Breast lumps
- ☐ Birth control: _____

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand/wrist pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Hip pain

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Bad temper
- ☐ Dizziness
- ☐ Lack of coordination
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Other neurological or psychological problems

_____

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 may be made by cash, check, credit or debit cards (visa/mastercard only).

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