Lynn Teo, MSc, MAOM, L.Ac
Licensed Acupuncturist & Shiatsu Therapist
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Health History Questionnaire

Please Note: all your answers are held absolutely confidential.

Personal Information

Name_____ Date_____

Street _____ City _____ State _____ Zip _____

Cell Phone_____Other Phone _____ Email _____

Age ____ Date of Birth _____ Sex: Male Female Height _____ Weight _____

Occupation: _____ Family Physician & Phone Number _____

Emergency Contact & Phone Number _____ Relationship to You _____

Referred By _____ Have you ever had acupuncture before? ❒ Yes ❒ No

Chief Complaints

Main Problem you would like addressed _____

_____

_____

_____

How long ago did this problem begin? Please be specific: _____

_____

_____

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

_____

What other kinds of treatment have you tried?

❒ Western Medicine ❒ Acupuncture ❒ Herbs ❒ Reiki ❒ Massage

❒ Physical Therapy ❒ Chiropractic ❒ Homeopathy ❒ Other_____

Secondary Complaints you would like address: _____

_____

_____

_____

_____

Past Medical History

Past Personal Medical History of Significant Illnesses ❒ Asthma ❒ Allergies ❒ Diabetes ❒ Cancer

❒Heart disease ❒ Stroke ❒ Hepatitis ❒ High Blood Pressure ❒ Seizures ❒ Rheumatic Fever

❒ Thyroid Disease ❒ Venereal Disease Other: _____

Hospitalizations / Surgeries (including dates): _____

_____

_____

_____

Significant Trauma (Auto accidents, falls, etc) : _____

_____

Allergies (Drugs, chemicals metals, foods) : _____

_____

Family Medical History: (check all that are applicable): ❒ Asthma ❒ Allergies ❒ Diabetes

❒ Cancer ❒ Heart disease ❒ Stroke ❒ Hepatitis ❒ High Blood Pressure ❒ Seizures

❒ Rheumatic Fever ❒ Thyroid Disease ❒ Venereal Disease Other: _____

Medicine taken with the last two months (vitamins, drugs, herbs, etc):_____

_____

_____

Lifestyle

Are there any areas of your life that you find stressful? Please describe:_____

_____

Do you have a regular exercise program? ❒ No ❒ Yes If yes, please describe: _____

_____

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related or other)?

❒ No ❒ Yes If yes, what type of diet: _____

_____

Describe your average daily diet:

Morning: _____ Afternoon: _____

Evening: _____ Snacks: _____

Do you smoke? ❒ No ❒ Yes **If yes, how many cigarettes or cigars per day?** _____

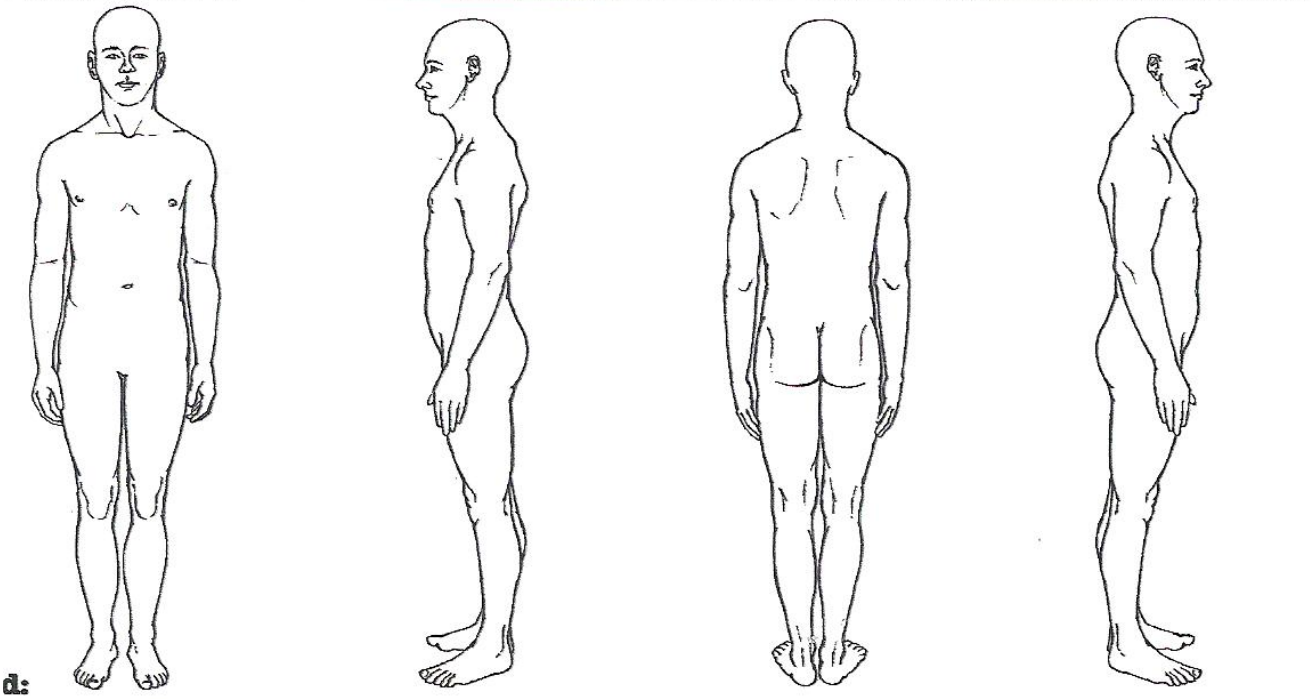
How many cups of caffeinated coffee, tea, or cola do you drink per week? _____

How many 8 oz glasses of water do you drink a day? _____

How many alcoholic beverages do you drink a week? _____

Please describe any use of drugs for non-medical purposes: _____

Please indicate any painful or distressed body areas by circling the particular area:



Please check if you have had any of the following particularly in the last three months:

GENERAL:

❒ Fevers ❒ Poor sleeping ❒ Weight gain ❒ Bleed or bruise easily?
❒ Chills ❒ Night sweats ❒ Change in appetite
❒ Fatigue ❒ Weight loss
❒ Sweat easily ❒ Cravings
❒ Peculiar tastes or smells Strong thirst for: ❒ Hot drinks ❒ Cold drink
❒ Sudden energy drop, if so what time of day? _____

SKIN & HAIR:

❒ Rashes ❒ Eczema ❒ Recent Moles ❒ Changes in hair or skin texture
❒ Ulcerations ❒ Pimples ❒ Psoriasis
❒ Hives ❒ Dandruff ❒ Dermatities
❒ Itching ❒ Loss of Hair ❒ Acne

Any other skin or hair problems? _____

HEAD, EYES, EARS, NOSE & THROAT:

❒ Dizziness
❒ Eye strain
❒ Color blindness
❒ Ringing in ears
❒ Nose bleeds
❒ Facial pain
❒ Concussions
❒ Eye pain
❒ Cataracts
❒ Spots in front of eyes
❒ Recurrent sore throats
❒ Sores on lips or tongue
❒ Migraines
❒ Poor vision
❒ Blurry vision
❒ Poor hearing
❒ Grinding teeth
❒ Teeth problems
❒ Glasses
❒ Night blindness
❒Earaches
❒ Sinus problems
❒ Clenching jaw
❒ Jaw clicks

❒ Headaches, where and when?_____
❒ Any other head or neck problems?_____

CARDIOVASCULAR:

❒ High blood pressure
❒ Irregular heart beat
❒ Cold hands or feet
❒ Varicose or spider veins
❒ Low blood pressure
❒ Difficulty in breathing
❒ Swelling of hands
❒ Palpitations
❒ Chest pain
❒ Fainting
❒ Blood clots
❒ Phlebitis
❒ Swelling of feet
❒ Palpitations at rest

❒ Any other heart of blood vessel problems?_____

RESPIRATORY:

❒ Cough
❒ Coughing blood
❒ Asthma
❒ Bronchitis
❒ Pneumonia
❒ Pain with deep breath
❒ Chest tightness
❒ Difficulty breathing when lying down
❒ Phlegm production, what color?_____

GASTROINTESTINAL:

❒ Nausea
❒ Gas
❒ Indigestion
❒ Bleeding gums
❒ Hernia
❒ Colitis
❒ Vomiting
❒ Belching
❒ Bad breath
❒ Food stagnation
❒ Excessive appetite
❒ Slow digestion
❒ Diarrhea
❒ Black stools
❒ Rectal pain
❒ Bloating/edema
❒ Poor appetite
❒ Constipation
❒ Blood in stools
❒ Hemorrhoids
❒Acid reflux/GERD
❒ IBS/Crohn's disease
❒ Abdominal pain/cramps
❒ Chronic laxative use
❒ Loose stools, more than 2 per day

❒ Any other problem with Stomach or intestines_____

GENITO-URINARY:

❒ Frequent urination
❒ Urgency to urinate
❒ Decrease in flow
❒ Blood in urine
❒ Unable to hold urine
❒ Impotency
❒ Pain upon urination
❒ Kidney stones
❒ Sores on genitals

❒ Any particular color to your urine? _____
❒ Do you wake up at night to urinate? If yes, how many times a night? _____
❒ Any other problems with your genital or urinary systems?_____

REPRODUCTIVE & GYNECOLOGIC:

Are you pregnant? ❒ Yes ❒ No
Is it possible that you are pregnant? ❒ Yes ❒ No
Number of pregnancies: _____ Live Births: _____ Miscarriages: _____
Abortions: _____ Premature births:_____
Age at first menses: _____ Time period between menses:_____
Duration of menses:_____ Last PAP: _____

❒ Irregular periods ❒ Painful periods ❒ Vaginal discharge ❒ Polycystic Ovarian disease
❒ Vaginal sores ❒ Clots ❒ Vaginal dryness
❒ Uterine fibroids ❒ Breast lumps ❒ Endometriosis ❒ Fibrocystic breast tissue
❒ Unusual character of blood (heavy, scanty)_____
Do you practice birth control? ❒Yes ❒ No If yes, what type? _____ How long? _____

MUSCULOSKELETAL:

❒ Neck pain ❒ Rotator cuff ❒ Knee pain ❒ Foot/ankle pain
❒ Muscle pain ❒ Muscle spasm ❒ Muscle weakness ❒ Shoulder pain
❒ Hip pain ❒ Sciatica ❒ Bursitis ❒ Hand/wrist pain
❒ Carpal tunnel ❒ Sprains/strains ❒ Tendonitis
❒ Back pain: Low_____ Middle_____ Upper_____
❒ Soreness/weakness of lower body (back, hip, knee, ankle, foot)

NEUROLOGICAL & PSYCHOLOGIC AL:

❒ Seizures ❒ Dizziness ❒ Bad temper ❒ Easily susceptible to stress
❒ Poor memory ❒ Concussion ❒ Loss of balance
❒ Anxiety ❒ Depression ❒ Poor coordination
❒ Nervousness ❒ ADD/ADHD ❒ Areas of numbness
Have you ever been treated for emotional problems? ❒ Yes ❒ No
Have you ever considered or attempted suicide? ❒ Yes ❒ No
Any other neurological or psychological problems?_____
_____

COMMENTS: *Please tell us briefly of any other problems you would like to discuss.*

_____
_____
_____
_____
_____
_____
_____

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Consent to Treatment

I hereby request and consent to the performance of Acupuncture, Shiatsu and other Oriental Medicine procedures on me (or on the patient named below, for whom I am legally responsible) by Lynn Teo, L.Ac. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, shiatsu therapy, Gua Sha manual therapy, Chinese Herbal Medicine, nutritional counseling, non-insertive acupoint stimulation, and / or magnet therapy.

Acupuncture involves the insertion of various styles and sizes of acupuncture needles into my body at various depths and locations. Shiatsu Therapy is a bodywork technique that uses pressure, tapping, and stretching of acupuncture channels and points. The amount of pressure applied is under the client's control. Acupuncture and Shiatsu Therapy attempt to normalize physiological functions, to modify the perception of pain and to treat certain diseases of dysfunction in the body. I have been informed that Acupuncture and Shiatsu are safe methods of treatment, but does carry certain risks, including pneumothorax, and burn. These risks are very uncommon when performed by a licensed practitioner. Occasionally, there may be some bruising or tingling, and scarring. I wish to rely on my Acupuncturist to exercise judgment during the course of treatment to employ procedures which the Acupuncturist feels at that time, based on the facts then known, is in my best interests. _____ **initials**

The herbs (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately if I become pregnant. If I experience any gastrointestinal reactions to the herbs I will inform the Acupuncturist immediately. _____ **initials**

I have been informed that I have the right to refuse any form of treatment. I have read, or have had read to me, the above consent. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with this treatment, and have been given an opportunity to ask questions pertaining to the treatment. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. _____ **initials**

I agree to pay all charged incurred for services rendered. I agree to pay a $100 charge for any missed or forgotten appointments without 24-hour notice of cancellation. _____ **initials**

By signing below, I agree to the above-named procedures.

Patient (or Guardian if patient is under 18 years of age) Signature:_____

Printed name of patient: _____ Date: _____

Therapist Signature: _____