Jade Spring Wellness Center

ACUPUNCTURE • MASSAGE THERAPY • CHINESE HERBAL MEDICINE

PATIENT HEALTH HISTORY QUESTIONNAIRE

Current Date: _____

Name _____ Sex_____ DOB _____ Age _____

Phone (home)_____ (work)_____ (cell)_____

Would you like reminder call ☐ text ☐ or none ☐ ?

Street

_____

City_____ State_____ Zip_____

Email_____ Would you like to receive our monthly online newsletters? No

Occupation_____ Marital Status_____

Family Physician _____ (Phone) _____

Emergency Contact (name) _____ (relation)_____(phone)_____

Whom may we thank for referring you?_____

Have you been treated by acupuncture, oriental medicine, or massage before?_____

What are the main problem(s) you would like us to help you with?

How long did this problem begin? *(be specific)* _____

To what extent does this problem interfere with your daily activities? (work, sleep, sex)

Have you been given a diagnosis for this problem(s)?

_____

What kind of treatments have you tried?_____

Do you have a pacemaker?_____

8529 124th Avenue NE Kirkland, WA 98033 * Ph (425)803-2050 Fax (425)803-2053
www.jadespringwellnesscenter.com

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General

- [ ] Alcoholism
- [ ] Anxiety
- [ ] Anemia
- [ ] Cancer
- [ ] Chronic Fatigue Syndrome
- [ ] Depression
- [ ] Drug Addiction
- [ ] High Cholesterol
- [ ] HIV/AIDS
- [ ] Diabetes
- [ ] Hyperthyroidism
- [ ] Hypothyroidism
- [ ] Insomnia
- [ ] Fatigue
- [ ] Fibromyalgia
- [ ] Gout
- [ ] Hypoglycemia
- [ ] Osteoarthritis
- [ ] Rheumatoid arthritis
- [ ] Shingles
- [ ] Stress

Body Regulation

- [ ] Day sweats
- [ ] Hot flashes
- [ ] Night sweats
- [ ] Aversion to Heat
- [ ] Aversion to Cold
- [ ] Cold hands/feet
- [ ] Excessive Thirst
- [ ] Thirst but no desire to drink
- [ ] No thirst

Gastrointestinal

- [ ] Gastrointestinal
- [ ] Gallbladder problems
- [ ] Liver Problems
- [ ] Distress w/ greasy foods
- [ ] Abdominal pain
- [ ] Belching
- [ ] Abdominal bloating
- [ ] Food Allergies
- [ ] Heartburn
- [ ] Nausea
- [ ] Diarrhea
- [ ] Blood in stool
- [ ] Constipation
- [ ] Mucus in Stools
- [ ] Undigested food in stool
- [ ] Colitis
- [ ] Ulcers
- [ ] Hiatal Hernia
- [ ] Vomiting
- [ ] Bitter taste in mouth
- [ ] Recent weight gain
- [ ] Recent weight loss
- [ ] Other _____

Cardiovascular

- [ ] Pain over heart
- [ ] Heart attack
- [ ] Swelling in ankles
- [ ] Irregular heart beat
- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Stroke
- [ ] Palpitations
- [ ] Other_____

Nervous System

- [ ] Nervous System
- [ ] Dizziness
- [ ] Vertigo
- [ ] Fainting
- [ ] Discoordination
- [ ] Numbness/Tingling
- [ ] Epilepsy
- [ ] ALS
- [ ] Parkinson's Disease
- [ ] Multiple Sclerosis
- [ ] Other_____

Ear, Nose, Throat

- [ ] Vision Problems
- [ ] Hearing Loss
- [ ] Ear Pain
- [ ] Tinnitus
- [ ] Dental Problems
- [ ] Nose Bleeds
- [ ] Difficulty breathing
- [ ] Sore throat
- [ ] Hoarseness
- [ ] Difficult speech
- [ ] Other_____

Urinary Tract

- [ ] Blood in Urine
- [ ] Difficult urination
- [ ] Urinary Infections
- [ ] Painful Urination
- [ ] Bladder Infection
- [ ] Kidney Stones
- [ ] Other_____

Respiratory

- [ ] Allergies
- [ ] Chest pain
- [ ] Spitting up blood
- [ ] Shortness of breath
- [ ] Chronic cough
- [ ] Coughing phlegm
- [ ] Emphysema
- [ ] Asthma
- [ ] Other _____

Sleep

- [ ] Difficulty falling asleep
- [ ] Difficulty staying asleep
- [ ] Difficulty waking
- [ ] Waking unrested
- [ ] Vivid Dreams
- [ ] Nightmares
- [ ] Restlessness
- [ ] Other _____

Skin

- [ ] Acne
- [ ] Allergic Dermatitis
- [ ] Bruise easily
- [ ] Cysts
- [ ] Dandruff
- [ ] Moles
- [ ] Psoriasis
- [ ] Rashes
- [ ] Other _____

Women Only

- [ ] Irregular Periods
- [ ] Menstrual cramps
- [ ] Spotting
- [ ] Excessive flow
- [ ] Headaches with period
- [ ] Painful breasts
- [ ] Lumps in breasts
- [ ] Mastectomy
- [ ] Hysterectomy
- [ ] Premenstrual Depression
- [ ] Vaginal Discharge
- [ ] Menopausal Symptoms
- [ ] Heavy Periods
- [ ] Other _____

Men Only

- [ ] Burning Urination
- [ ] Difficulty passing urine
- [ ] Night Urination
- [ ] Incomplete bowel movement
- [ ] Prostate trouble
- [ ] Dripping after urination
- [ ] Other_____

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Informed Consent for

Massage Health Issues: (Check all that apply)

- ☐ Allergies
- ☐ Ankle/Foot Pain
- ☐ Arthritis
- ☐ Back Pain
- ☐ Blood Clots
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Carpal Tunnel
- ☐ Cardiac Problems
- ☐ Circulatory Problems
- ☐ Diabetic
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Fever
- ☐ Headaches
- ☐ Heart
- ☐ High/Low Blood Pressure
- ☐ Hip/Knee Pain
- ☐ Joint Swelling
- ☐ Low Back Pain
- ☐ Nausea
- ☐ Pregnant
- ☐ Pinched Nerve
- ☐ Recent Injury
- ☐ Recent Surgery
- ☐ Seizure
- ☐ Skin Rash
- ☐ Stress
- ☐ Varicose Veins

Other: _____

Are you feeling any of the following? (Please Circle)

Tension Soreness Numbness Stabbing Pain

What type of massage would you like?

Deep Tissue Injury Specific Relaxation Sports

Which area(s) do you want to focus on? _____

Please inform the massage therapist if you are taking any medications or are under the care of a medical professional for a specific condition.

Informed Consent Agreement

- Please consult your Primary Physician before receiving massage if you are pregnant, have a fever or contagious skin/virus condition, have asthma or faint easily.
- I have disclosed all my known physical conditions and medications and I will keep the massage therapist updated on any changes.
- I understand that massage therapy is not a substitute for medical treatment or medication. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.
- I understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, and improve circulation.
- If at any time during the massage *anything* feels uncomfortable, I will speak up so the pressure and technique can be adjusted to my needs.
- With my signature, I agree to pay the full office charge for appointments cancelled or broken without 24 hours advance notice.

I give my consent for treatment. (Please sign when you arrive at our physical location.)

Signed:_____ Date:_____

Consent for Acupuncture Treatment & Associated Therapies

I, the undersigned, authorize the National and Washington State licensed Acupuncturists at Jade Spring Wellness Center to perform the following procedures:

Acupuncture: The insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.

Electroacupuncture: Using very small amounts of electricity to stimulate specific acupuncture points.

Infrared Heat: Applying heat generated by an infrared lamp over a specific area of the body.

Cupping: Glass cups are placed on the skin with a vacuum created by heat or suction device.

Gua Sha: a rubbing technique on an area of the body with a round instrument.

Moxa: an indirect warming technique on an acupuncture point using an herbal stick, string or ball moxa to relieve symptoms.

Massage & Acupressure: Medical massage and manual therapy.

Liniments, Oils, Plasters, Tapes: Herbal formulas applied topically to the skin.

Herbal Consultations: as dietary advice based on the Traditional Chinese Medical Theory.

I recognize the potential risk and benefits of these procedures as described below.

Potential Risk: discomfort, pain, infection, and blistering at the site of procedure, temporary discoloration of the skin, and even aggravation of symptoms existing prior to the acupuncture treatment.

Potential Benefits: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention, or elimination of presenting health problems.

I understand that I need to notify the acupuncturist if I have a pacemaker, a bleeding disorder, or if I am pregnant or plan to become pregnant.
With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me regarding cure or improvement of my condition. I hereby release the National and Washington State licensed Acupuncturists at Jade Spring Wellness Center 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 that I am free to withdraw consent and to discontinue participation in these procedures at any time. (Please sign when you arrive at our physical location.)

Signature of Patient_____ Date_____

Or of person authorized to consent_____ Date_____

With my signature, I acknowledge that I have read the above statement and agree to pay the full office charge for appointments cancelled or broken without 24 hours advance notice. I also understand that my insurance will be billed as a courtesy, if I so request, but any balance is due and payable by me. I authorize the National and Washington State licensed Acupuncturists at Jade Spring Wellness Center to release any information required to process my claims and authorize my insurance company to make payment directly to my provider. (Please sign when you arrive at our physical location.)

Signature of Patient_____ Date_____