



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? Y / N		
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? _____



Jade Spring Wellness Center

ACUPUNCTURE • MASSAGE THERAPY • CHINESE HERBAL MEDICINE

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 _____



Informed Consent for Massage

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: _____