

THE TEAL CENTER

For Therapeutic Bodywork, Ltd.



Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask. If there is anything you wish to bring to our attention, which is not asked on this form, please note it in the "Comments" section. Thank you.

Name: _____ Date: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Telephone (H) _____ (C) _____ (W) _____

Date of birth: _____ Height: _____ Weight: _____

Occupation: _____ Marital Status: _____ Referred by: _____

Emergency Contact: _____
Name Phone number

Would you like to receive e-mail notifications on promotional discounts/ newsletter? Yes No

Have you been treated by acupuncture or Oriental medicine before? Yes No

Main problem(s) you would like us to help you with:

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

To what extent does this problem interfere with you daily activities, such as work sleep, and sex?

Have you been given a diagnosis for this problem? If so, what? _____

What kinds of treatment have you tried? _____

Past Medical History (please include date)
Significant Illnesses (please circle applicable)

Cancer	Diabetes	Hepatitis	High Blood Pressure	Heart Disease
Rheumatic Fever	Thyroid Disease	Seizures	Venereal Disease	Other

Surgeries: _____

Significant trauma (auto accidents, falls, etc.): _____

Allergies (drugs, chemicals, foods): _____

Family Medical History

Diabetes Cancer High Blood Pressure Heart Disease
Rheumatic Fever Thyroid Disease Seizures Venereal Disease Other

Medicines taken within the last two months (vitamins, drugs, herbs, etc.):

Occupational Stress (chemical, physical, psychological): _____

Do you have a regular exercise program? If yes, please describe:

Have you ever been on a restricted diet? If yes, what kind? _____

Please describe your average daily diet:

Morning:

Afternoon:

Evening:

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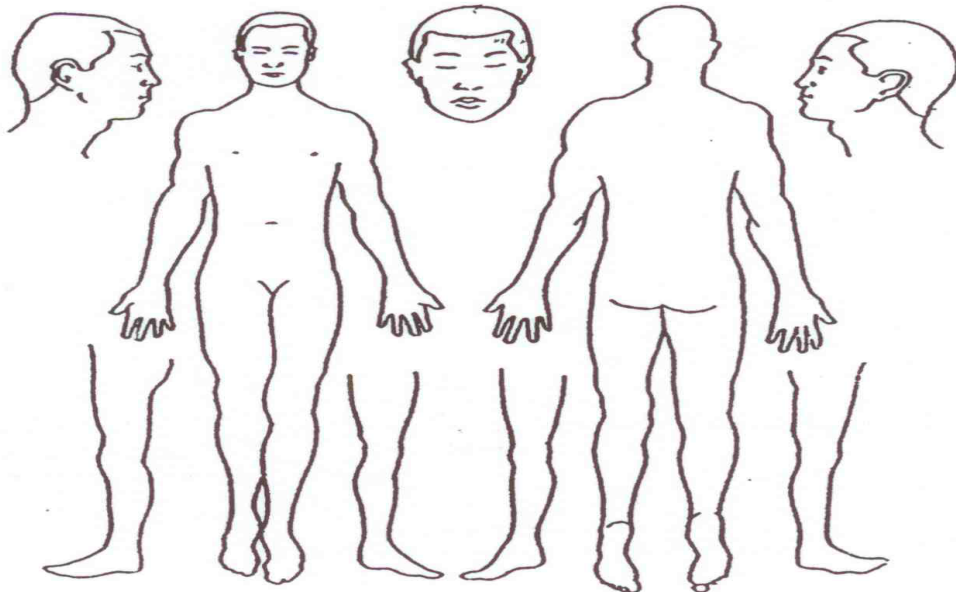
How much water do you drink per day? _____

Do you smoke? If yes, how much? _____

How much caffeinated coffee, tea, or cola do you drink per week? _____

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

Indicate any painful or distressed areas



Please check if you have had (in the last three months):

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Poor sleeping | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Peculiar tastes or smells | <input type="checkbox"/> Sudden energy drop (what time of day?) | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Strong thirst (hot or cold drinks?) | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Change in appetite | |

Head, eyes, ears, nose, and throat

- | | | |
|---|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Color blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Headaches (where, when?) |
| <input type="checkbox"/> Any other head or neck problems? | | |

Cardiovascular

- | | | |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Difficulty in breathing | |
| <input type="checkbox"/> Any other heart or blood vessel problems? | | |

Respiratory

- | | | |
|--|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with deep breath |
| <input type="checkbox"/> Difficulty in breathing when lying down | <input type="checkbox"/> Production of phlegm; what color? | |
| <input type="checkbox"/> Any other lung problems? | | |

Gastrointestinal

- | | | |
|--|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Any other problems with your stomach or intestines? | | |

Genito- Urinary

- | | | |
|--|---|--|
| <input type="checkbox"/> Pain upon urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Any particular color to your urine: |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Kidney stones | |
| <input type="checkbox"/> Decrease in urine flow | <input type="checkbox"/> How many times per day do you urinate? _____ | <input type="checkbox"/> Do you wake up to urinate? How often? _____ |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Sores on genitals | |
| <input type="checkbox"/> Impotence | | |
| <input type="checkbox"/> Any other problems with your genital or urinary system? | | |

Musculoskeletal

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Foot/ ankle pains |
| <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Any other joint or bone problems? | | |

WOMEN'S FERTILITY HISTORY

NAME (LAST, FIRST, MIDDLE)

CONFIDENTIAL

DATE

Age at which menses began _____

Date of last menstrual period _____

How many days do you normally bleed? _____

Are your menstrual cycles spaced irregularly?
Yes No

How many days are there from from one period
to the next? _____

Are your periods painful? Yes No

How many days does the pain last? _____

How heavy is the bleeding?
Light Normal Heavy

What color is the blood?

Light red Red Dark red Purple Brown Black

Is there clotting? Yes No

Do you have premenstrual tension? Yes No

Does your face break out before or during your
period? Yes No

Do your breasts become tender premenstrually?
Yes No

Do you bleed or spot between periods? Yes No

How many pregnancies have you had? _____

How many children do you have? _____

How many abortions have you had? _____

How many miscarriages have you had? _____

How many times has a D&C
been performed? When? _____

Have you ever had an abnormal pap smear?
Yes No

Have you ever had a cervical biopsy,
operation, cauterization or conization? Yes No

Have you ever had a venereal disease? Yes No

Do you get yeast infections regularly? Yes No

Have you ever been diagnosed with a chlamydial
infection? Yes No

Do you have chronic vaginal discharge? Yes No

Do you have any sores on your genitalia? Yes No

Have you ever had pelvic inflammatory disease?
Yes No

Were you treated for it? Yes No

How? _____

Date of last Pap smear _____

Results _____

Have you ever been diagnosed with uterine
fibroids or polyps? Yes No

Have you ever been diagnosed with
endometriosis? Yes No

Have you been diagnosed with pelvic adhesions?
Yes No

Have you been diagnosed with poly-cystic
ovarian syndrome? Yes No

Have you been diagnosed with any pelvic
abnormalities? Yes No

Have you taken any medications for gynecological
conditions other than contraceptives?

Medication	Reason	How long
------------	--------	----------

_____	_____	_____
-------	-------	-------

_____	_____	_____
-------	-------	-------

_____	_____	_____
-------	-------	-------

Have your cycles changed since they began?
Yes No

If so, how? _____

Do you ovulate on your own? Yes No

On what day of your cycle? _____

Do your breasts get tender at/during ovulation?
Yes No

Do you get premenstrual low back pain? Yes No

Do your bowel movements become loose at the
beginning of you period? Yes No

Women's Fertility History Continued

Do you chart your Basal Body Temperature? Y/N
(If yes, please bring copy of past 3 months)
How long have you been trying to conceive?

Have you had a diagnosis relating to infertility?
Yes No
Have you had fertility treatments? Yes No
If yes, when and where? _____

By whom? _____
What types? _____

Have you taken medication to help you ovulate?
Yes No
When _____ How long? _____

Have your fallopian tubes been evaluated
medically? Yes No
What were the results? _____
Have you had any tubal operations? Yes No
Have you had any hormone laboratory tests
performed? Yes No
What were the results?
FSH _____ LH _____
Estrodiol _____ Progesterone _____
Prolactin _____

Do you have a single partner with whom you have
been trying to conceive? Yes No
How long have you been married or living
together? _____
Has he had a fertility workup? Yes No
What were the results? _____

Is your partner supportive of your wish to
conceive? Yes No
Do you have any problems with sexual desire,
sensation, performance and/or orgasm?
Yes No
If yes, please explain _____

Do you douche regularly? Yes No
With what? _____

Do you use vaginal lubricants? Yes No
Are you more than 20% over your ideal body
weight? Yes No
Are you more than 20% below your ideal body
weight? Yes No

Do you have a stressful occupation? Yes No
Do you exercise regularly? Yes No
Do you have excessive facial hair? Yes No
Do you have excessively oily skin? Yes No
Have you experienced excessive loss of head
hair? Yes No

Have you noticed discharge from your nipples?
Yes No

Was your mother exposed to
diethylstilbestrol (DES) when she was pregnant
with you? Yes No

Have you been exposed to any
known environmental toxins or hormones?
Yes No

Are you presently taking steroids? Yes No
Have you taken oral contraceptives? Yes No
When? _____
How long? _____

Have you ever had an IUD? Yes No
When? _____
How long? _____
Have you ever taken DepoProvera? Yes No
When? _____
How long? _____

Is there a family history of stroke, heart attack,
DVT, hypertension or pulmonary embolism
BEFORE the age of 65? _____
(If so, it is advised to test for Thrombophilia , a
blood clotting disorder which can cause
recurrent miscarriages.)

The Teal Center for Therapeutic Bodywork, Ltd.
Acupuncture & Chinese Herbal Medicine Informed Consent

Please take time to read this form, which will provide you with some basic information about acupuncture treatment.

Important Things to Keep in Mind Regarding Acupuncture Treatment:

- Always feel free to communicate with your practitioner about what you are experiencing during the treatment or any questions you may have about the treatment.
- Clients experience a wide variety of sensations when receiving acupuncture treatment. You may not feel much, or you may feel a small, sharp sensation as the needle is inserted. Once the needles are in, it is common to feel a sense of general relaxation, tingling, movement, temperature change, or mild achiness at the site of a needle or elsewhere; these are all positive signs that your body is responding to treatment. If a needle ever continues to feel sharp past the moment of insertion, let your acupuncturist know so that the needle can be adjusted to a more comfortable position.
- If you experience dizziness, nausea, a cold sweat, shortness of breath, or faintness during treatment, please tell your acupuncturist immediately. These symptoms may occur and are generally caused by anxiety when receiving acupuncture for the first time.
- While the needles are in place, relax and breathe fully, but do not change your position or move suddenly, as you may experience some discomfort at the needle sites.
- Maintain good personal hygiene.
- You will be more comfortable during your treatment if you have eaten prior to the session but are not excessively full.

Acupuncture and Related Techniques

I understand that I may be treated with one or more of the following techniques. I understand that not all techniques are indicated for every person or condition, and I am free to ask my practitioner for more information about techniques to be used in my treatment.

- Insertion of needles into the body at various depths and locations
- Application of heat to the skin using moxa (an herb) or a conventional heat lamp
- A massage technique called "gua sha." This treatment leaves redness on the skin that may last from 1-5 days. Slight bruising or tenderness may persist after treatment.
- Cupping to promote circulation. Cups may produce a red/purple color on the area treated lasting for 1-5 days
- Electrical stimulation of the needles using an electro-acupuncture device
- The expression of a few drops of blood from an acupuncture point may be performed to improve circulation. A lancet is inserted into the skin and a few drops of blood are expressed.
- Therapeutic herbal consultation: Herbal and nutritional supplements (which are derived from plant, animal, and mineral sources) that may be recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro intestinal upset or allergic reactions to the herbs, I will inform my acupuncturist

Infectious Disease Prevention

I understand that my acupuncturist uses only sterile, single-use, disposable needles and follows universally prescribed precautions such as clean needle technique and hand washing to prevent the transmission of infectious disease.

Risks / Possible Side Effects

I understand that in some cases acupuncture may result in certain side effects, including local bruising, slight bleeding, dizziness, fainting, minor burns resulting from the use of heat therapies, temporary pain or discomfort, and/or temporary aggravation of symptoms existing prior to treatment.

Patient Responsibilities

I understand that it is my responsibility as a patient to inform my acupuncturist about all aspects of my health and, as treatment progresses, to inform my practitioner of changes that occur. If I experience any pain, discomfort, or possible adverse side effects, it is my responsibility to immediately notify my practitioner. I acknowledge that I am ultimately responsible for my own health and self-care. Making healthy lifestyle choices can substantially support my healing process and enhance the outcome of the acupuncture treatments I receive.

Confidentiality

I understand that the confidentiality of my file and the information I share in the course of treatment will be honored and preserved. I acknowledge that my practitioner is ethically and legally required to report certain information pertaining to the abuse of minors and elders or serious threats of violence.

Treatment Outcomes

I understand that each individual responds uniquely to treatment and, for this reason, my practitioner cannot guarantee the outcome of treatment. Some individuals experience total or partial relief of their symptoms after the first few treatments. Others notice a steady, gradual improvement. Occasionally, some people notice that their symptoms seem to worsen before they improve. I agree to share my responses with my acupuncturist at each follow-up visit so that my treatment plan can be adjusted accordingly.

By signing this informed consent form, I acknowledge that I have read the information above carefully and that I consent to receive acupuncture treatment.

Name (Print)_____

Patient Signature_____

Date_____

Parent Signature (if patient is a minor)_____

Date_____

The Teal Center for Therapeutic Bodywork, Ltd.

CLIENT AGREEMENT

HIPPA regulations require the following signed authorization:

I (name)_____ (address)_____ give permission for my Teal Center practitioner to take notes about me, including health history/medical and/or personal information I choose to disclose. I understand that this information will be kept strictly confidential.

I also understand:

1. That massage therapy and/or acupuncture
 - ◆ is for the purpose of stress reduction, relief from muscular tension and spasm, general relaxation and improvement of circulation and energy flow;
 - ◆ is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.
2. That the massage therapists and/or acupuncturists
 - ◆ do not diagnose illness, disease or any other physical or mental disorder;
 - ◆ do not prescribe medical treatment or pharmaceuticals; and
 - ◆ do not perform any spinal manipulations.
3. That any and all of my appointment times are reserved exclusively for me and that I am responsible to remember them and to pay for appointments that I miss or cancel with less than 24 hours notice.

I authorize The Teal Center to charge my credit card on file for the full amount of any appointment missed or cancelled with less than 24 hours notice.

I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Name_____

Signature_____ Date_____

Welcome! And thank you for choosing The Teal Center.

Please read and ***initial*** each of the following

POLICIES

_____ Appointments missed, cancelled or rescheduled with less than 24 hours notice will be charged in full. To avoid being charged for a missed appointment, we invite you to send a friend or family member in your place. Also, if we can fill appointments that are missed, cancelled or rescheduled with less than 24 hours notice the client will not be charged. *It is your responsibility to remember your appointments.* Confirmation calls are made 36-48 hours prior to the scheduled appointment.

_____ The Teal Center and its practitioners abide by the ethical standards of practice established by their respective certification boards (NCBTMB and NCCAOM). All clients shall refrain from any behavior that sexualizes or appears to sexualize the client/therapist relationship. If such behavior occurs at any time, therapists are instructed to terminate the session; payment will be made in full by the client and the Teal Center reserves the right to prohibit the client from returning to the Teal Center.

_____ If you have a cold or other contagious illness, please call us before your appointment so we can check with your therapist to see if it is appropriate for you to come in.

_____ In order to preserve a peaceful environment, we ask that you silence your cell phones while at The Teal Center.

_____ Tips are appreciated but *never* expected. If you wish to leave a gratuity for your therapist we ask that you do so in cash or by check made directly to the therapist.

_____ If you move or change phone numbers, it is your responsibility to inform us. This is important so we can reach you in case of any emergency or any necessary and unforeseen scheduling changes.

_____ The Teal Center does not submit insurance claims. We are happy to provide you with medical receipts, any treatment notes and payment history for your personal records. We will communicate directly with your insurer *at their request only.*