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

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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? ____________________________________

<u>Past Medical History</u> (please include date)
Significant Illnesses (pleas circle appicable)

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:

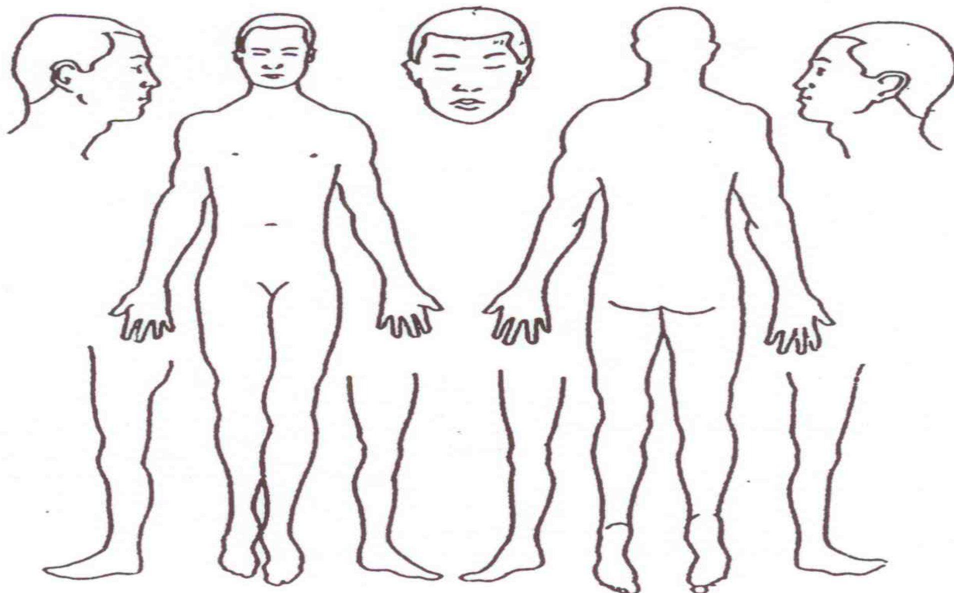
How much water do you drink per day? ______________________________

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):

- ☐ Fevers
- ☐ Sweat easily
- ☐ Chills
- ☐ Bleed or bruise easily
- ☐ Poor sleeping
- ☐ Weight loss
- ☐ Peculiar tastes or smells
- ☐ Sudden energy drop (what time of day?)
- ☐ Strong thirst (hot or cold drinks?)
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight Gain

Head, eyes, ears, nose, and throat

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

Cardiovascular

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

Respiratory

- ☐ Cough
- ☐ Coughing blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pain with deep breath
- ☐ Difficulty in breathing when lying down
- ☐ Production of phlegm; what color?
- ☐ Any other lung problems?

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Poor appetite
- ☐ Any other problems with your stomach or intestines?

Genito- Urinary

- ☐ Pain upon urination
- ☐ Unable to hold urine
- ☐ Any particular color to your urine:
- ☐ Urgency to urinate
- ☐ Kidney stones
- ☐ Decrease in urine flow
- ☐ How many times per day do you urinate? _______
- ☐ Do you wake up to urinate? How often? _________
- ☐ Blood in urine
- ☐ Impotence
- ☐ Sores on genitals
- ☐ Any other problems with your genital or urinary system?

Musculoskeletal

- ☐ Neck pain
- ☐ Muscle pain
- ☐ Knee pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Foot/ ankle pains
- ☐ Hand/wrist pain
- ☐ Shoulder pain
- ☐ Hip pain
- ☐ Any other joint or bone problems?

Reproductive and gynecologic

# of pregnancies_____	☐ vaginal discharge	☐ menstrual clots
# of live births ______	☐ breast lumps	☐ unusual periods (heavy, light, etc)
# of premature births _____	☐ menopause: age ____	☐ spotting or pain between periods
# of miscarriages _____	☐ irregular periods	Date of last pap_____ Results ______
# of abortions _____	☐ menstrual pain Age of 1st menses _________	
Date of last period _____	# of days period lasts _____	

Changes in body/ psyche prior to period:

Do you practice birth control? What type and for how long?

Is there a chance that you are pregnant now?

Neuropsychological

☐ Seizures	☐ Lack of coordination	☐ Loss of balance
☐ Areas of numbness	☐ Depression	☐ Poor memory
☐ Concussions	☐ Easily susceptible to stress	☐ Anxiety
☐ Bad temper	☐ Tremors	

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems?

Comments:
Please tell us of any other problems you would like to discuss.

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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 you 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.*