

# 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**

Significant Illnesses (please check box) Diabetes  
Cancer Hepatitis High Blood Pressure Heart Disease  
Rheumatic Fever Thyroid Disease Seizures Venereal Disease Other (please specify)

Surgeries: \_\_\_\_\_

Significant trauma (auto accidents, falls, etc.): \_\_\_\_\_

Allergies (drugs, chemicals, foods): \_\_\_\_\_

**Family Medical History** (please check box)

Diabetes                      High Blood Pressure                      Heart Disease                      Cancer  
Rheumatic Fever                      Thyroid Disease                      Seizures                      Venereal Disease                      Other (please specify)

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? \_\_\_\_\_

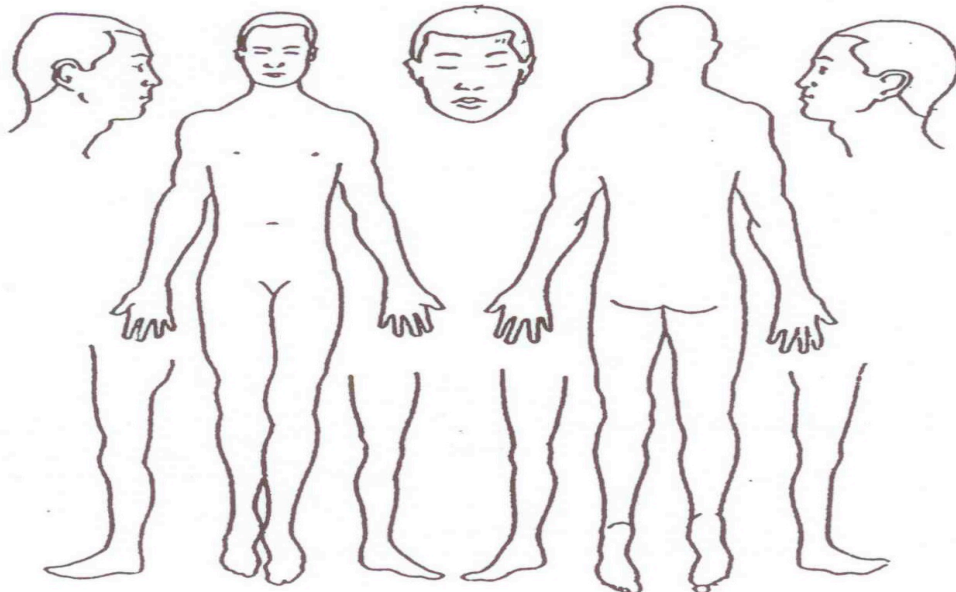
Do you smoke? If yes, how much? \_\_\_\_\_

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 print out form and circle area with pen\*



**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"/>   | <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? |  |  |

**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 and Results \_\_\_\_\_  
# of abortions \_\_\_\_\_  menstrual pain Age of 1<sup>st</sup> 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 \_\_\_\_\_

\*Do not fill out. Please print out and bring with you to your initial acupuncture visit\*

## Recommendation for a Diagnostic Examination

**WE, THE UNDERSIGNED, DO AFFIRM THAT \_\_\_\_\_  
(NAME OF PATIENT) HAS BEEN ADVISED BY \_\_\_\_\_  
(NAME OF LICENSED ACUPUNCTURIST), TO CONSULT A  
PHYSICIAN REGARDING THE CONDITION FOR WHICH  
ACUPUNCTURE TREATMENT IS BEING SOUGHT.**

\_\_\_\_\_  
(Signature of patient)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of acupuncturist)

\_\_\_\_\_  
(Date)

The Code of Virginia requires that prior to performing acupuncture, a licensed acupuncturist shall either "(i) obtain written documentation that the patient had received a diagnostic examination from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry with regard to the ailment or condition to be treated or (ii) provide to the patient a written recommendation for such a diagnostic examination." (§54.1-2956.9 of the Code of Virginia)

### **Instructions to Licensed Acupuncturist:**

The law requires the Board of Medicine to adopt a standard form to be used by licensed acupuncturists in recommending a diagnostic examination. **Therefore, this form must be given to any patient seeking acupuncture treatment from whom the acupuncturist has not obtained written documentation of a diagnostic examination from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry for the ailment or condition being treated.**

- The form must be in duplicate with one copy to be given to the patient and one copy kept on file with the patient's records.
- The form must be signed and dated by both the patient and the licensed acupuncturist.
- If the patient does not understand English, the licensed acupuncturist must either provide the form in the language of the patient or ensure that it has been translated for the patient in his language.

The Teal Center for Therapeutic Bodywork, Ltd.

CLIENT AGREEMENT

HIPAA 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, bodywork and 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, bodyworkers and 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, cancel or reschedule 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, cancelled or rescheduled with less than 24 hours notice.

I have stated all my known medical conditions, agree to keep my practitioners updated on my physical health and to update my medical history as necessary.

Name\_\_\_\_\_

Signature\_\_\_\_\_ Date\_\_\_\_\_



# **POLICIES**

Please **READ** and **INITIAL** each of the following

Welcome! Thank you for choosing The Teal Center!

\_\_\_\_\_ 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.*