Easley Theraputic Massage and Wellness Center

Health History and Questionnaire

Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they play a major role in diagnosis and treatment. All of the information is strictly confidential.

Date: ____________________ Email: ____-__________________

Name: ____ Date of Birth: ________/________/_______ Age:___________

Gender: ☐Male ☐Female Social Security Number: _____________-_________-_____________ Occupation: ___________________________

Address: ____ City: ____________________ State: __________ Zip Code: _______________

Home Phone: ________________________________ Cell Phone: ____________________________________

Height: ____________ Weight: _____________ Family Physician: __________________________________ Last Seen: ___________________

Emergency Contact: ____ Emergency Contact Phone: _________________________________

Referred By: ____

Relationship Status: ☐ Single ☐Married/Life Partner ☐Divorced/Separated ☐ Widowed

Have you been treated by Acupuncture or Oriental Medicine in the past? ☐ Yes ☐ No

What is/are the main problem(s) you would like help with? ____

How long ago did this problem begin? ______________ What kinds of treatments have you tried? _______________________________________

Have you been given a diagnosis for this problem? If so, what? By whom? ____

To what extent does this problem interfere with our daily activities? ____

Past/Current Medical History:

☐ Cancer	☐ High Blood Pressure	☐ Thyroid Disease	☐ Seizures
☐ Rheumatic Fever	☐ Heart Disease	☐ Hepatitis	☐ Venereal Disease
☐ Diabetes	☐ HIV/AIDS	☐ Asthma/Pneumonia	☐ Anemia

Other (include chronic illnesses): ____

Surgeries, significant traumas, and/or hospitalizations (type and date): ____

____

Are you currently pregnant? ☐ Yes ☐ No How many weeks? ______________ What is your due date? _____________________

Allergies (drug, chemical, food): ____

Medications/Supplements taken within the last two months: ____

____

Check any of the following that have occurred in your blood relatives:

☐ Diabetes	☐ Allergies	☐ Mental Illness	☐ High Blood Pressure
☐ Obesity	☐ Alcoholism	☐ Heart Disease	☐ High Cholesterol
☐ Cancer	☐ Kidney Disease	☐ Nervous System Disease	☐ Arteriosclerosis
☐ Stroke	☐ Tuberculosis	☐ Bleeding Tendency	☐ Other: ________________________________

Do you exercise regularly? ☐ Yes ☐ No Type of exercise: ____

How many cigarettes smoked per day: ________________ How much nicotine chewed per week: ________________

How many alcoholic drinks per week: ________________ How many caffeinated drinks per day: ________________

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

Please Check any symptom(s) you have had in the last three months:

General:

☐ Sudden energy drop ☐ Localized weakness ☐ Fevers ☐ Chills ☐ Fatigue ☐ Poor Sleep

☐ Sleep disorders ☐ Sweat easily ☐ Night sweats ☐ Tremors ☐ Poor balance ☐ Weight gain

☐ Weight loss ☐ Bleed/bruise easily ☐ Edema (where): ________________________________

☐ Pain: Where: ____________________ Time of day: __________ Level (1 - 10) __________

☐ Energy level (1 - 10) ______________

Head, Eyes, Ears, Nose, and Throat:

☐ Dizziness ☐ Migraines ☐ Facial Pain ☐ Headaches (when & where): ______________

☐ Glasses ☐ Poor Vision ☐ Night Blindness ☐ Blurry Vision

☐ Blind Field ☐ Eye Pain ☐ Eye Strain ☐ Spots in front of eyes/floaters

☐ Cataracts ☐ Eye Dryness ☐ Excessive tearing ☐ Discharge from eyes

☐ Hearing Aids ☐ Earaches ☐ Poor Hearing ☐ Discharge from ears

☐ Ringing in ears ☐ Nose Bleeds ☐ Sinus Congestion ☐ Nasal Drainage

☐ Grinding Teeth ☐ Dental Problems ☐ Jaw Clicks ☐ Loss of Consciousness

☐ Concussions ☐ Hoarseness ☐ Recurrent sore throat ☐ Sores on lips or tongue

☐ Other head or neck problems:____

Skin and Hair:

☐ Rashes ☐ Itching ☐ Ulcerations ☐ Eczema ☐ Hives ☐ Changes in hair or skin

☐ Pimples ☐ Recent Moles ☐ Dandruff ☐ Loss of hair ☐ Foot Fungus ☐ Oozing of skin lesions

☐ Other hair, skin, or foot problems: ____

Cardiovascular:

☐ High Blood Pressure ☐ Low Blood Pressure ☐ Chest Discomfort/Pain ☐ Heart Palpitations

☐ Cold hands/feet ☐ Swelling of hands ☐ Swelling of feet ☐ Fainting

☐ Blood clots ☐ Other heart or blood vessel problems: ________________________________

Respiratory:

☐ Allergies ☐ Cough ☐ Asthma/Wheezing ☐ Pain with deep breathing ☐ Shortness of breath

☐ Pneumonia ☐ Bronchitis ☐ Difficulty Inhaling ☐ Difficulty Exhaling ☐ Coughing blood

☐ Production of phlegm (what color?): ______________ ☐ Other lung problems: ______________________

Musculo-Skeletal:

☐ Neck Pain ☐ Shoulder Pain ☐ Back Pain ☐ Elbow Pain ☐ Hand/Wrist Pain

☐ Knee Pain ☐ Foot/Ankle Pain ☐ Muscle Pain ☐ Hip Pain ☐ Muscle Weakness

☐ Other muscular/skeletal problems: ____

Urinary:

☐ Pain on urination ☐ Urgency to urinate ☐ Frequent Urination ☐ Profuse Urination ☐ Retention of urine

☐ Blood in urine ☐ Decrease in flow ☐ Dribbling ☐ Kidney Stones ☐ Waking to urinate

☐ Other genital/urinary problems: ____

Diet/Gastrointestinal:

☐ Peculiar taste or smell ☐ Strong thirst ☐ No desire to drink ☐ Change in appetite ☐ Poor appetite

☐ Digestive allergies ☐ Bad breath ☐ Nausea ☐ Vomiting ☐ Heartburn

☐ Belching ☐ Indigestion ☐ Diarrhea ☐ Constipation ☐ Chronic laxative use

☐ Blood in stool ☐ Black stools ☐ Abdominal distention ☐ Abdomen tense/firm ☐ Abdominal pain/cramps

☐ Gas ☐ Rectal pain ☐ Hemorrhoids ☐ Epigastric pain ☐ Other stomach/intestinal problem

Psycho-emotional:

☐ Insomnia ☐ Irritability ☐ Anxiety ☐ Depression ☐ Los of control/violence potential ☐ Substance abuse

☐ Easily susceptible to stress Have you ever been treated for emotional problems? ☐ Yes ☐ No

Have you ever considered or attempted suicide? ☐ Yes ☐ No

Neurological:

☐ Seizures ☐ Weakness ☐ Poor Memory ☐ Loss of balance ☐ Lack of coordination ☐ Areas of numbness

☐ Vertigo/dizziness ☐ Concussion/loss of consciousness

Sexual/Genital:

☐ Changes in sexual drive ☐ Sores on genitals ☐ Pain in the genital area

Female:

☐ Heavy Periods ☐ Light Periods ☐ Painful Periods ☐ Irregular Periods ☐ Clots

☐ Vaginal Discharge ☐ Vaginal Sores ☐ Breast lumps ☐ Nipple discharge ☐ Post-coital bleeding

Age of first menses: ______ Days between menses: ______ Number of days: ________ First day of last menses: ________

Color of blood: ☐ Bright red ☐ Normal red ☐ Purple ☐ Dark brown Date of last pap smear: __________________

Menopause: ☐ Yes ☐ No Age: ____________ Do you use birth control? ☐ Yes ☐ No What type? ________________________

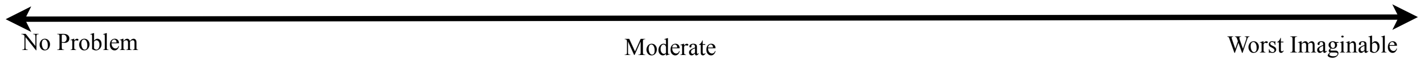
# of pregnancies: _______ # of births: ________ # of premature: _______ # of miscarriages: __________ #of abortions: ___________

Male:

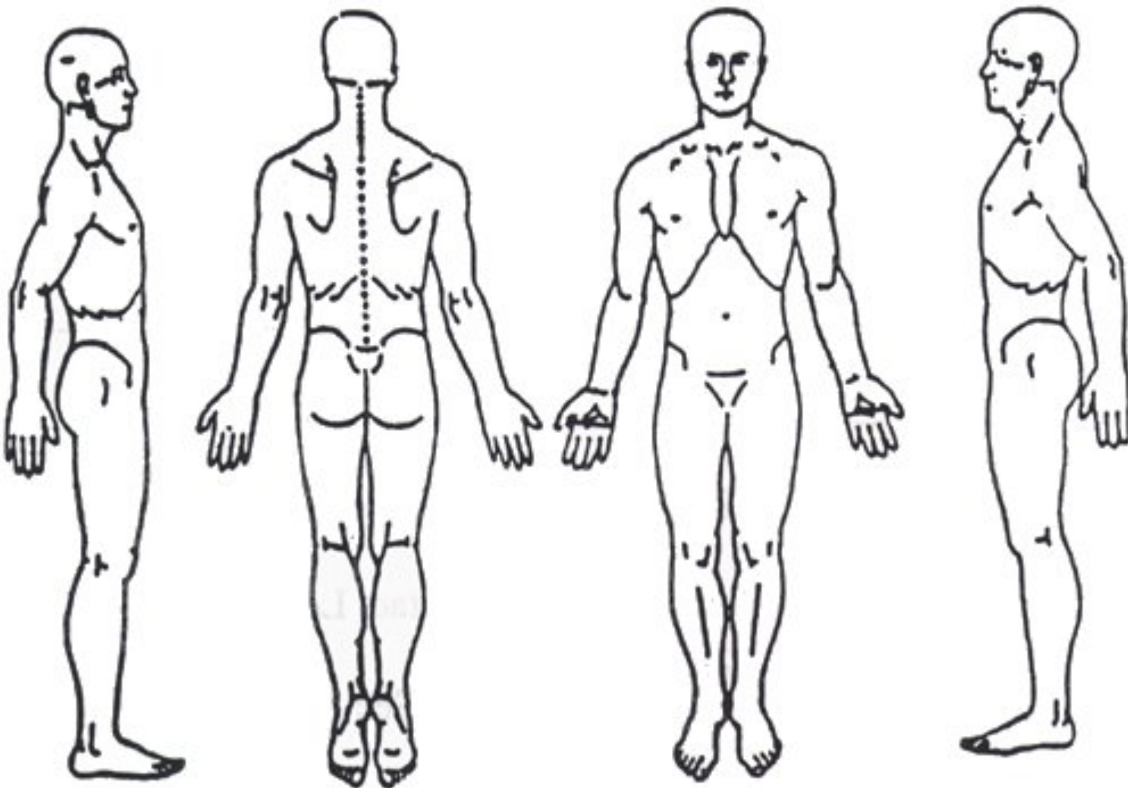
☐ Impotence ☐ Prostate problems ☐ Premature ejaculation/wet dream ☐ Other issues: ________________________________

Please note the degree of severity of your main problem now:

Please note the greatest degree of severity of your main problem within the last week:



Please indicate painful or distressed areas with a circle or "X"



Easley Theraputic Massage and Wellness Center

I, ____, hereby consent to be treated by Mandi Thompson L.Ac., with acupuncture and/or Oriental Medicine procedures, which may include acupuncture, moxibustion, cupping, electrical stimulation, auricular therapy, Tui Na (Chinese Medical massage), Chinese herbal medicine, or nutritional and lifestyle counseling.

I understand that acupuncture is preformed by the insertion of pre-sterilized acupuncture needles through the skin, with or without the addition of heat or electrical stimulation, to certain points on the body, with the intent of improving bodily functions, relieving pain, and treating certain diseases or bodily dysfunctions.

I have been informed that acupuncture, when preformed by qualified licensed practitioners, is a safe method of treatment, but rarely, some side effects can occur. The most common of these are bruising or tingling near the needling site for a few days, fatigue, or temporary aggravation of pre-existing symptoms. Other possible though extremely rare side effects may be fainting, spontaneous miscarriage, or pneumothorax. If I experience any symptoms I believe may be a result of treatment, or if I have questions or concerns regarding my treatments, I've been advised to contact my acupuncturist promptly for guidance.

I understand that I should also inform my acupuncturist prior to being treated if I believe that I might be pregnant.

I accept the fact that no guarantee is made concerning the outcome of my acupuncture or herbal medicine treatments and that I may stop treatments at any time.

PATIENT'S NAME ____

PATIENT'S SIGNATURE ____

ACUPUNCTURIST'S SIGNATURE ____

DATE ____________________________

I, ____ (patient's or patient's representative's name printed), have been advised by Mandi Thompson L.Ac. to consult a physician regarding the condition or conditions for which such patient seeks acupuncture/herbal medical treatment if necessary.

____
Patient's name

____ ____________________________
Patient's or patient's representative's signature Date

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Notice of Privacy Practices

Our office is dedicated to providing respectful and confidential services. Protecting your privacy and healthcare information is fundamental to our practice, and is also mandated by law.

Please be advised that we may gather personal and health information about you in several ways:

- ✦ Directly from you, our patient
- ✦ From other healthcare providers
- ✦ From third party payers (i.e., insurance companies)

Not that we may use and disclose medical information about you (without your specific consent or authorization for the following reasons only:

- ✦ To confer with other healthcare practitioners to better understand the optimal course of treatment
- ✦ To facilitate payment from insurance companies for the treatment and services you receive from us
- ✦ To share our findings with your referring primary care practitioners

We may disclose your medical information to any other medical practitioners, friends, or family only with your written consent. You may request a medical information disclosure form from our office.

Communication:

I routinely communicated with patients over the phone to schedule appointments, to address concerns, or answer questions. If I leave a message, I will identify myself by name and mention I am from Lotus Moon Acupuncture.
If you prefer to only be contacted at work, home, or other phone number, please write that number here:
____

Patient Rights:

- ✦ Upon written request, you have the right to access, review, or receive copies of your healthcare records.
- ✦ Upon written request, you have the right to request that I place restrictions on the disclosure of your protected health information. In your request, you must indicated what information you want to limit. I am not required to agree to this request
- ✦ You are entitled to a copy of this notice
- ✦ Upon written request, you have the right to a summary of what I have disclosed about you and to whom.

Complaints:

If you have questions or complaints, please contact Mandi Thompson at (864) 306-0336. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to:

DHEC at ***scdhec.gov***
or email ***compliance@dhec.sc.gov***

*By signing below, I acknowledge that I have read, reviewed, understood, and agreed to the statement of *Privacy Policy* for healthcare services with Lotus Moon Acupuncture. I also confirm that this office has attempted to provide me with a copy of the statement of privacy policies.

____

(Patient signature) (Date)

A WORD ABOUT SCHEDULING

I strive to make my office run as smoothly as possible and to help make your experience here as satisfying and pleasant as I can.

To do this, I allow plenty of time for your visit. Unlike many physicians' offices that schedule six to eight patients per hour to compensate for those who do not show up, I regularly see only one or two people per hour. For a first visit, an entire hour and a half is set aside just for you.

To enable me to continue this level of individualized attention, however, I must insist that the time we set aside for you is respected. Consequently, should you be unable to keep your appointment, I require notice of at lease 24 hours before your appointment time.

If you forget your appointment, if you are running late and cannot make the appointment, if you have transportation difficulties, or if you call to cancel with less that 24 hours notice, I am obliged to charge you the full fee for the visit. Naturally, I will make an exception to this in the event of genuine emergencies, such as acute illness or accidents. Also, if another time slot is available the same day as your missed appointment, I will gladly switch your time slot with no penalty. If, however, no other time is available that day, you will still be charged for your missed appointment.

This policy is not intended to be punitive. It simply allows me to keep an appointment schedule that favors longer visits. This means my patients spend less time in the waiting room and more time in consultation and treatment with me.

I am grateful for your cooperation and goodwill in this matter.

Sincerely,

Mandi Thompson, L.Ac, LMT

Please sign below to acknowledge that you have read my scheduling policy and that you accept these terms. Thank you.

X ____