



SEATTLE INSTITUTE OF ORIENTAL MEDICINE  
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## HEALTH HISTORY QUESTIONNAIRE

\_\_\_\_\_  
Home Telephone #

\_\_\_\_\_  
Alternate Telephone #

Last Name		First Name		Nickname	Height	Weight	
Age	DOB	Place of Birth					
Address			City, State, Zip				
Email		Emergency Contact Name		Telephone			
Employer Name & Address							
Family Physician			Referred By				
Have you been treated by acupuncture or oriental medicine before?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have you had massage therapy or chiropractic treatment before?		<input type="checkbox"/> YES	<input type="checkbox"/> NO

Main problem(s) you would like to be treated for:
How long ago did this problem begin (please be specific)?
To what extent does this problem interfere with your daily activities?
Have you been given a diagnosis for this problem? If so, describe:
What kinds of treatment have you tried?

**PAST MEDICAL HISTORY** (please include dates)

<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Thyroid Disease	_____
<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> STDs	_____
<input type="checkbox"/> Other			
<input type="checkbox"/> Surgeries (type & date)			
<input type="checkbox"/> Significant Trauma (auto accidents, falls, etc.)			
<input type="checkbox"/> Significant Dental Work			
<input type="checkbox"/> Birth History	(Prolonged labor, c-section, etc.)		
<input type="checkbox"/> Allergies			

**FAMILY MEDICAL HISTORY**

<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Thyroid Disease	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Stroke	_____

**Medications**

Please include any taken within the last two months, including vitamins, herbs, etc.

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<input type="checkbox"/> Occupational Stress	
<input type="checkbox"/> Regular exercise program	
<input type="checkbox"/> Restricted diet	
<input type="checkbox"/> Smoke	Number of cigarettes per day:
<input type="checkbox"/> Coffee/tea/soda	Number of servings per week:
<input type="checkbox"/> Alcohol	Number of servings per week:
<input type="checkbox"/> Non-medicinal drug use	

**Describe your average daily diet.**

Morning	
Afternoon	
Evening	

**PLEASE CHECK ANY SYMPTOMS YOU HAVE HAD IN THE PAST THREE MONTHS**

GENERAL	SKIN AND HAIR	HEAD, EYES, EARS, NOSE, THROAT
<input type="checkbox"/> Poor appetite <input type="checkbox"/> Fever <input type="checkbox"/> Sweat easily <input type="checkbox"/> Localized weakness <input type="checkbox"/> Bleed or bruise easily <input type="checkbox"/> Peculiar taste or smells <input type="checkbox"/> Strong thirst (cold or hot) <input type="checkbox"/> Low thirst <input type="checkbox"/> Sudden energy drop What time of day? _____ <input type="checkbox"/> Poor sleeping <input type="checkbox"/> Chills or tremors <input type="checkbox"/> Poor balance <input type="checkbox"/> Fatigue <input type="checkbox"/> Night sweats <input type="checkbox"/> Cravings <input type="checkbox"/> Weight gain/loss	<input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Dandruff <input type="checkbox"/> Change in hair or skin <input type="checkbox"/> Ulcerations <input type="checkbox"/> Eczema <input type="checkbox"/> Hair loss <input type="checkbox"/> Hives <input type="checkbox"/> Acne <input type="checkbox"/> Recent moles <input type="checkbox"/> Other hair or skin problems _____	<input type="checkbox"/> Grinding teeth <input type="checkbox"/> Dental problems <input type="checkbox"/> Concussion <input type="checkbox"/> Eye strain <input type="checkbox"/> Night blindness <input type="checkbox"/> Blurry vision <input type="checkbox"/> Poor hearing <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Facial pain <input type="checkbox"/> Jaw clicks <input type="checkbox"/> Migraines <input type="checkbox"/> Eye pain <input type="checkbox"/> Color blindness <input type="checkbox"/> Earaches <input type="checkbox"/> Spots in eyes <input type="checkbox"/> Recurrent sore throat <input type="checkbox"/> Lip or tongue sores <input type="checkbox"/> Headaches <input type="checkbox"/> Other head or neck problems _____
	<b>HEAD, EYES, EARS, NOSE, THROAT</b>	
	<input type="checkbox"/> Dizziness <input type="checkbox"/> Glasses <input type="checkbox"/> Poor vision <input type="checkbox"/> Cataracts <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems	

CARDIOVASCULAR	GENITO-URINARY	NEUROPSYCHOLOGICAL
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Blood clots <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Dizziness <input type="checkbox"/> Swelling of hands or feet <input type="checkbox"/> Phlebitis <input type="checkbox"/> Chest pain <input type="checkbox"/> Fainting <input type="checkbox"/> Difficulty in breathing <input type="checkbox"/> Other heart or blood vessel problems	<input type="checkbox"/> Pain during urination <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> Decrease in flow <input type="checkbox"/> Frequent urination <input type="checkbox"/> Unable to hold urine <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones <input type="checkbox"/> Impotency <input type="checkbox"/> Genital sores <input type="checkbox"/> Other genital or urinary problems: _____ <input type="checkbox"/> Do you wake up to urinate? If so, how often? _____ <input type="checkbox"/> Any particular color to your urine: _____	<input type="checkbox"/> Seizures <input type="checkbox"/> Areas of numbness <input type="checkbox"/> Concussion <input type="checkbox"/> Bad temper <input type="checkbox"/> Dizziness <input type="checkbox"/> Lack of coordination <input type="checkbox"/> Depression <input type="checkbox"/> Easily susceptible to stress <input type="checkbox"/> Loss of balance <input type="checkbox"/> Poor memory <input type="checkbox"/> Anxiety <input type="checkbox"/> Other neurological or psychological problems _____
<b>RESPIRATORY</b>	<b>PREGNANCY &amp; GYNECOLOGY</b>	
<input type="checkbox"/> Cough <input type="checkbox"/> Bronchitis <input type="checkbox"/> Difficulty in breathing when lying down <input type="checkbox"/> Production of phlegm What color? _____ <input type="checkbox"/> Coughing blood <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Pain while breathing deeply <input type="checkbox"/> Other lung problems: _____	<input type="checkbox"/> Number of pregnancies _____ <input type="checkbox"/> Number of births _____ <input type="checkbox"/> Premature births _____ <input type="checkbox"/> Miscarriages _____ <input type="checkbox"/> Abortions _____ <input type="checkbox"/> Age at first menses _____ <input type="checkbox"/> # days between periods _____ <input type="checkbox"/> Duration _____ <input type="checkbox"/> First date of last period _____ <input type="checkbox"/> Unusual character _____	
<b>GASTROINTESTINAL</b>	<input type="checkbox"/> Painful periods <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> PMS <input type="checkbox"/> Clots <input type="checkbox"/> Vaginal sores <input type="checkbox"/> Irregular periods <input type="checkbox"/> Last Pap _____ <input type="checkbox"/> Breast lumps <input type="checkbox"/> Birth control: _____	
<input type="checkbox"/> Nausea <input type="checkbox"/> Constipation <input type="checkbox"/> Black stools <input type="checkbox"/> Bad breath <input type="checkbox"/> Abdominal pain or cramps <input type="checkbox"/> Chronic laxative use <input type="checkbox"/> Vomiting <input type="checkbox"/> Gas <input type="checkbox"/> Blood in stools <input type="checkbox"/> Rectal pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Belching <input type="checkbox"/> Indigestion <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Other stomach or intestinal problems: _____	<b>MUSCULOSKELETAL</b>	
	<input type="checkbox"/> Neck pain <input type="checkbox"/> Back pain <input type="checkbox"/> Hand/wrist pain <input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Foot/ankle pain <input type="checkbox"/> Hip pain	

## CONSENT FOR TRADITIONAL CHINESE MEDICINE

I, the undersigned, hereby authorize the student interns and/or clinical faculty of the Seattle Institute of Oriental Medicine to perform the following specific procedures:

**Herbal prescriptions:** May be given in the form of pills, powders, tinctures, pastes, plasters, or in raw form to be cooked. Cooked herbs may be given to take internally, or externally as a wash. **Herbal formulas may include shell, mineral, and animal products.**

**If you do not want animal-based products used in your formula, please notify your practitioner at every visit when herbs are prescribed.**

**Acupuncture:** Insertion of special sterilized needles through the skin into underlying tissues at specific points on the body. Because the needles are sterile and are only used one time, it is not necessary to swab the skin with alcohol prior to insertion; however, feel free to request this from your practitioner.

**Tui-Na:** A form of massage therapy relying on specific hand techniques, pressure on acupuncture points, and isolated stretching. This technique involves close physical contact, during which the practitioner may be on the treatment table with the patient.

**If you are being treated in the tui-na clinic, please make sure that your student-practitioner is aware of any specific musculoskeletal complaints that you have or other medical conditions for which you have sought treatment.**

**Cupping:** Cups made of glass, bamboo, or other materials are placed on the skin with a vacuum created by heat or other device. Some bruising may result.

**Plum Blossom or Seven Star Hammer:** Light tapping of an area of the body with a small sterile hammer which has seven points.

**Gua Sha:** Rubbing or scraping of an area of the body with a blunt, round instrument. Some bruising may result.

**Moxibustion:** Heating an acupoint using stick, string, or ball moxa to create a warming effect.

### **I RECOGNIZE THE POTENTIAL RISKS AND BENEFITS OF THESE PROCEDURES AS DESCRIBED BELOW:**

**Potential risks:** Discomfort, pain, infection or blistering at the site of the procedure; temporary discoloration of skin; nausea; loose bowel movements; abdominal cramping; and aggravation of symptoms existing prior to the acupuncture treatment. Treatment may also result in other side effects.

**Potential benefits:** Drugless relief of presenting symptoms and improved balance of bodily energies, which can lead to prevention or elimination of the presenting problem and strengthen the constitution.

**With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the Seattle Institute of Oriental Medicine, or any of its personnel, regarding cure or improvement of my condition.**

**I hereby release the Seattle Institute of Oriental Medicine and its practitioners from any and all liability which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand I am free to withdraw my consent and to discontinue participation in these procedures at any time.**

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Signature of patient or guardian

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Date

## SIOM CLINIC FINANCIAL POLICY

The Seattle Institute of Oriental Medicine provides low cost, quality medical care in a teaching clinic setting. The following financial policy has been established to support the administration of the clinic and its mission.

The fee for the Student Intern Clinic is \$30. In this clinic, patients are treated by second and third year student interns under the supervision of experienced practitioners.

The fee for the Preceptorship Clinic is \$40. In this clinic, patients are treated by experienced practitioners while up to six students assist the practitioner. The \$40 fee is approximately half of a private practitioner's fee.

The fee for the First-Year Tuina Clinic is \$20. In this clinic, patients are treated by first-year student interns under the supervision of experienced practitioners.

The fee for the Advanced Tuina Clinic is \$30. In this clinic, patients are treated by second-year student interns under the supervision of experienced practitioners. In the advanced clinic, patients may receive acupuncture treatment in addition to tuina.

Herbs vary in price and are not included in the above clinic fees.

Our goal is to make acupuncture available to those who might not be able to afford it otherwise. We are not set up to file insurance claims or to accept delayed payments. We do not bill for services, and we ask for payment in full at the time of service. Payments must be by cash or check; we do not accept credit or debit cards.

In an effort to keep our costs low, and to avoid raising the costs of our treatments, beginning on 1/1/08, we will no longer assist with insurance billing. This means we will not provide super-bills, fill out insurance forms, or respond to requests for records for insurance claims.

We do offer a limited reduced fee for those who are on Disability or Medicaid. Please ask at the front desk about these reduced fees.

We have limited clinic hours and there is often a waiting list. Therefore, we require 24 hours notice for changes or cancellations. **Appointments cancelled with less than 24 hours notice and appointments missed with no notification will be charged in full for that appointment.** Patients who qualify for a reduced fee will also be charged in full at the regular \$30 fee – not the reduced fee. Please pay for the missed visit at or before the next appointment. If you cancel two appointments with minimal or no notice, you will not be rescheduled until you have paid the cancellation fee for both visits. If there is a continued pattern of missed appointments, we may choose not to schedule you for appointments in the future. Please show our clinicians respect and plan ahead if you must cancel or change your appointment.

**By signing this form, I am indicating that I understand and accept this policy.**

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Signature

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Date