Date: ______________

Kaley Kopores
RAc. D.Ac. RMT

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. If we sincerely believe your condition will not respond satisfactorily, we will not accept your case. If you have any questions, please ask. If you have 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 of Birth: ______________ Age: ________

Address: ______________________________ Height: ________ Weight: ________ Sex: ________

______________________________ Employer: ______________________________

______________________________ Occupation: ______________________________

Phone: (H) ____________________(W) ____________________ (C) ____________________

Marital Status: ________ Email: ______________________________

Physician: ______________________________ How did you hear about me? ____________________

In Emergency, Notify: ____________________ Relationship: ______________ Phone: ____________

Main problem you would like help with: ______________________________

____

When did the problem begin (be specific): ______________________________

What makes it better? ______________________________

What makes it worse? ______________________________

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)? ______________

____

Have you been given a diagnosis for the problem? If so, what? ______________________________

What kind of treatments have you tried? ______________________________

Other concurrent therapies: ______________________________

Past Medical History – please note dates:

Cancer: ______________ HIV/AIDS: ______________ Thyroid Disease: ______________

Diabetes: ______________ High Blood Pressure: __________ Rheumatic Fever: ______________

Hepatitis: ______________ Heart Disease: ______________ Venereal Disease: ______________

Surgeries and Hospitalizations (types & dates):

____

____

Significant Traumas: ______________________________

____

Other: ______________________________

Allergies (drugs, chemicals, foods, etc.) ______________________________

Occupational Stress (chemical, physical, psychological) ______________________________

Date: ______________

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Family Medical History

☐ Cancer
☐ Diabetes
☐ High Blood Pressure
☐ Epilepsy
☐ Heart Disease
☐ Stroke
☐ Seizures
☐ Asthma
☐ Allergies
☐ Other __________

Medications

What medications and/or supplements are you currently taking? ____

____

Habits

Do you have a regular exercise program? Please describe: ____

____

Are you or have you been on a restricted diet? What kind and why? ____

____

Please indicate usage per day or per week:

Cigarettes _________________ per ______
Alcohol _________________ per ______
Drugs _________________ per ______
Coffee _________________ per ______
Tea _________________ per ______
Soft Drinks _________________ per ______
Sugar _________________ per ______
Other _________________ per ______

Do you suffer from any of the following?

Check all that apply, and for each note if it is current or past.

General

☐ Recurrent Infections
☐ Night Sweats
☐ Sweat easily
☐ Bleed or bruise easily
☐ Strong thirst (prefer hot or cold?)
☐ Thirst with no desire to drink
☐ Fatigue
☐ Sudden energy drops
Time of day____________
☐ Poor Sleep
☐ Tremors
☐ Poor Balance
☐ Edema
☐ Underweight
☐ Overweight

Skin

☐ Rashes
☐ Itching
☐ Eczema
☐ Oozing
☐ Pimples
☐ Dry skin / scalp
☐ Recent moles
☐ Changes in hair/skin
☐ Other __________

Head/Eyes/Ears/Nose/Throat

☐ Headaches
Where _________
When _________
☐ Migraines
☐ Dizziness
☐ Discharge from ear
☐ Poor hearing
☐ Ringing in ears
☐ Blurry vision
☐ Night blindness
☐ Color blindness
☐ Spots in front of eyes
☐ Eye Pain
☐ Excessive Tearing
☐ Squint
☐ Glasses
☐ Sore eyes
☐ Facial Pain
☐ Nose bleeds
☐ Nasal discharge
☐ Blocked nose
☐ Snoring
☐ Grinding teeth
☐ Teeth problems
☐ Recurrent sore throat
☐ Hoarseness
☐ Tonsillitis
☐ Swollen glands
☐ Sores on lips/mouth
☐ Other ____________

Date: ______________

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Cardiovascular
☐ Pacemaker
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Chest discomfort/pain
☐ Heart Palpitations
☐ Cold hands or feet
☐ Swelling of hands or feet
☐ Blood Clots
☐ Spider veins
☐ Fainting
☐ Other ____________

Respiratory
☐ Difficulty breathing
☐ Pain with breathing
☐ Shallow breathing
☐ Shortness of breath
☐ Production of phlegm
color _________
☐ Recurrent cough
☐ Bronchitis
☐ Pneumonia
☐ Asthma/Wheezing

☐ Other __________

Digestion
☐ Bad breath
☐ Change in appetite
☐ Nausea
☐ Vomiting
☐ Heartburn
☐ Indigestion
☐ Belching
☐ Abdominal pain or cramps
☐ Weight gain
☐ Weight loss
☐ Loose stools / Diarrhea
☐ Strong smelling stools
☐ Bloody stools
☐ Pale stools
☐ Green stools
☐ Black stools
☐ Constipation
(not daily, or difficult)
☐ Pain with passing stools
☐ Gas
☐ Rectal pain
☐ Hemorrhoids
☐ Anorexia nervosa
☐ Bulimia
☐ Other _________

Genito-urinary
☐ Pain on urination
☐ Urgency with urination
☐ Frequent urination
☐ Blood in urine
☐ Decrease in urinary flow
☐ Unable to hold urine
☐ Incontinence at night
☐ Dribbling urination
☐ Kidney stones
☐ Prostate problems
☐ Impotency
☐ Changes in sexual drive
☐ Rashes
☐ Do you wake at night to urinate?
How many times? __________
☐ Other ___________

Gynecological
# of pregnancies___________
births__________________
premature births_________
abortions_______________
Age of 1st menses__________
days between menses______
Duration of menses_________
1st day of last menses________
Age of menopause__________
Date of last PAP____________

☐ PMS
☐ Irregular periods
☐ Painful periods
☐ Light periods
☐ Heavy periods
☐ Clots
☐ Fibroids
☐ Endometriosis
☐ Infertility
☐ Vaginal discharge
☐ Vaginal sores
☐ Postcoital bleeding
☐ Breast lumps
☐ Nipple discharge
☐ Other __________

Do you practice birth control?
☐ yes ☐ no
what type and for how long?
____

Are you pregnant now?
☐ yes ☐ no

Musculoskeletal
☐ Neck ache/pain
☐ Back ache/pain
☐ Knee ache/pain
☐ Shoulder pain
☐ Elbow/Forearm pain
☐ Hand/Wrist pain
☐ Foot/Ankle pain
☐ Joint/Bone problems
☐ Torn tissues
☐ Prostheses
☐ Muscle pain/weakness
☐ Hernia
☐ Other ____________

Neurological
☐ Seizures
☐ Nerve damage
☐ Paralysis
☐ Stroke
☐ Sleep disorder
☐ Concussion
☐ Vertigo
☐ Lack of coordination
☐ Loss of balance
☐ Poor memory
☐ Difficulty in concentrating
☐ Other ______________

Behavioral
☐ Vacant
☐ Moody
☐ Easily susceptible to stress
☐ Aggressive/Bad temper
☐ Lose control of emotions
☐ Anxiety
☐ Panic Attacks
☐ Depression
☐ Fear
☐ Substance abuse
☐ Other _______________

Have you ever been treated for emotional problems?
☐ yes ☐ no

Have you ever considered or attempted suicide?
☐ yes ☐ no

ASSOCIATE
Massage Therapy
CLINIC LTD.
& LASER THERAPY
CENTER

Date: ______________

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Please rate the severity of your problem right now:

|____|

No Problem Worst Imaginable

Please rate the greatest degree of severity of your problem:

|____|

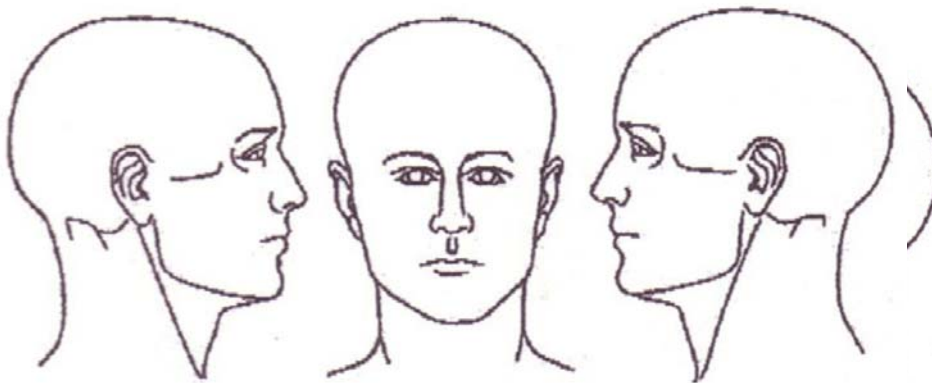
No Problem Worst Imaginable

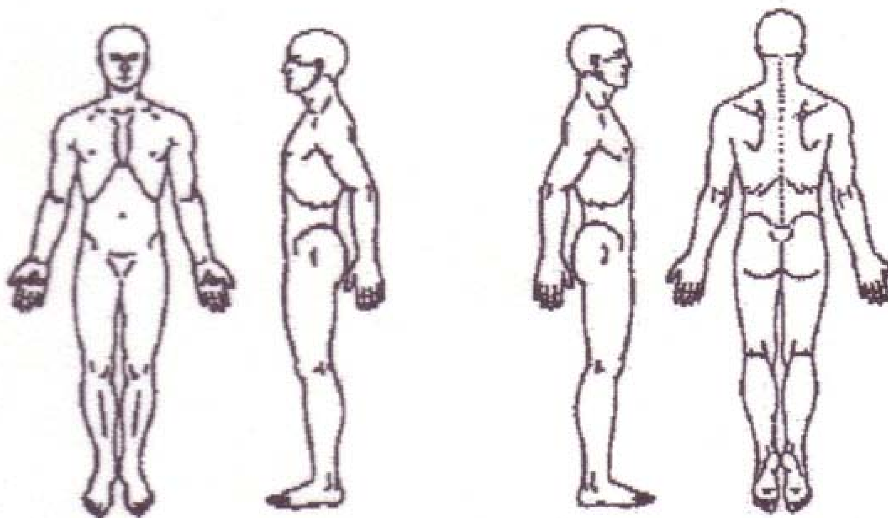
Please rate the severity of your pain at best:

|____|

No Problem Worst Imaginable

Please indicate areas of pain or distress. Use an arrow to show where the pain radiates if applicable:





Comments:____

Date: ______________

Kaley Kopores
RAc. D.Ac. RMT

Informed Consent to Treatment

By signing below, I ____, do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a Registered Acupuncturist.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on the body in order to treat bodily dysfunctions or diseases (as per Traditional Chinese Medicine), to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that there are no guarantees concerning its use and effects that are given to me and that I am free to stop the acupuncture treatment at any time.

Moxibustion: I understand that I may be given moxibustion. I understand that moxibustion is the application of indirect heat supplied by burning the herb Folium Artemisiae vulgaris, commonly know as "Mugwort plant", over a single or group of acupuncture points. The area of treatment may remain red and warm for several hours afterwards. I understand that I may stop the treatment if it is too uncomfortable. I will immediately notify the acupuncturist if I experience any symptoms or problems.

Acupressure/Tui Na: I understand that I may also be given acupressure/tui na massage as a part of my treatment. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may also be given electro-acupuncture (the application of an electric stimulus to the needles) with the acupuncture. I am aware that certain adverse side effects may result these may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms.

Cupping: I understand that cupping therapy denotes the use of glass or plastic cups that are placed on the body using suction. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: marks on the skin, bruising, sore muscles or aches and the possible aggravation of symptoms existing prior to treatment.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Clinic as soon as possible.*

Date: ______________

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RAc. D.Ac. RMT

Informed Consent To Treatment

I will notify my acupuncturist if I become pregnant or if I am in the process of trying to get pregnant so that the points and herbs can be avoided that could induce miscarriage or otherwise threaten or complicate the gestation and parturition.

I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that an acupuncturist is not a medical physician. I also understand that, whenever necessary, I must continue to seek treatment with a medical doctor for any conditions which cannot be resolved by acupuncture or Traditional Chinese Medicine.

I acknowledge that I am required to have made my health concerns known to a licensed physician during a scheduled visit prior to the commencement of any acupuncture or other Traditional Chinese Medicine methods of treatment used in this practice.

I understand my acupuncturist may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that I can discuss risks and benefits further with my acupuncturist before signing if I so choose. I do not expect my acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on my acupuncturist to exercise judgement during the course of treatment which the acupuncturist thinks at the time, based on the facts then known, is in my best interest.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a MINIMUM OF 6 HOURS NOTICE IS REQUIRED to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the FULL FEE WILL BE CHARGED for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this clinic.

If any provision of this Informed Consent is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the validity of any other provision.

By voluntarily signing this document, I hereby certify that I have carefully read, or have had read to me, the above consent to treatment, have been told about risks and benefits of acupuncture and other procedures, have had an opportunity to ask questions, and that I consent to the provisions described above. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I fully understand all the above information and am fully aware of what I am signing.

Registered Acupuncturist: Kaley Kopores R.Ac. D.Ac. RMT

Patient Signature:____Date:_____________________________

Patient's Printed Name:____