WENDY BECKER, BA, LMT, Dipl. L.Ac., EAMP, CNRT-M
2319 N. 45th St, Suite 305
Seattle, WA 98103

PATIENT HEALTH INFORMATION

Reason for Visit: *All treatments provided are therapeutic in nature and are non-sexual. Treatment plans are associated with individual subjective concerns of you, the patient and objective observations evaluated by me, the practitioner.*

Have you experienced ACUPUNCTURE? ❑No ❑Yes If yes, then was your last treatment? ___/___/___
What goal(s) do you want achieve with acupuncture? ____
Are you currently receiving other doctor, medical practitioner, or psychological care? ❑No ❑Yes If yes, please give name(s) of your provider(s) and reason(s):____
Do you have your physician's approval to receive massage and/or acupuncture? ❑Have Rx ❑Not Applicable

Have you experienced professional MASSAGE? ❑No ❑Yes If yes, when was your last treatment? ___/___/___
Results you expect from your massage session: ____
Check areas of your body that you have difficulty being touched (i.e. ticklishness, tenderness, tightness or personal discomfort): ❑scalp ❑ears ❑face ❑neck ❑back ❑chest ❑arms/hands ❑abdomen ❑buttocks ❑legs/feet ***OR***
❑I give permission to receive treatment on all areas listed. *Please note:* ❑I wear contact lenses.

Have you experienced CUPPING? ❑No ❑Yes I understand I can review ***Cupping & Gua Sha Information*** on website. _____Initials

AUTO (PIP) or EMPLOYMENT RELATED INJURIES How many days/weeks have you felt generally poor since DOI? _____ State mechanism of injury: ___________________ When did symptoms of condition/pain begin? ___/___/___
What is *current status of your condition* and quality of function & pain?
❑Worse ❑Better ❑Same ❑Constant ❑Intermittent ❑Improved Comments: ________________________________
Specific activities or movements stopped resulting from DOI, including, but not limited to:
❑Sitting ❑Walking ❑Standing ❑Lifting ❑Bending ❑Reclining Comments: ____________________________

Range of Motion: ❑Significantly restricted ❑Moderately restricted ❑Minimally restricted
❑*Other* (i.e. overall energy, emotion, appetite, function of bowel and/or urination, sweat, thirst, taste, peculiar changes you notice): ____
____
How would you describe your current quality sleep at night? ________________Hours you get? ___ Do you wake up rested? ❑Yes ❑No Explain ____
I understand and agree to keep a daily journal about my symptoms experienced since DOI? _____Initials

Health Information & Medical History

Have you had any recent colds, illnesses? ❑No ❑Yes Comments: ________________________________
Do you have allergies to scents, lotions, or oils? ❑No ❑Yes If yes, please list: ____________________________

Diagnostic Screenings

Do you have high blood pressure (>145/95)? ❑Yes ❑No Controlled? ❑Yes ❑No Today _____/_____
❑Autoimmune: _________________/___/___❑Cancer: _________________/___/___❑Diabetes: ___/___/___
❑Hepatitis: ___ ___/___/___ ❑High Cholesterol: __________/___/___ ❑HIV: ___/___/___ ❑TB: ___/___/___
❑Thyroid: _________________/___/___ ❑Other: _________________/___/___

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Describe your current exercise regimen: ____ Did you exercise today? ❑Yes ❑No *Activities:* ❑Aerobics ❑Dance/Martial Arts ❑Interval / Strength training ❑Yoga / Flexibility ❑Race / Game Effort ❑Casual Activity: _______________ ❑Physical Therapy

******For Women Only******
Are you menstruating? ❑Yes ❑No Are you pregnant? ❑No ❑Unsure ❑Yes ______months

Nutrition

Please list current nutritional supplements, herbs, or medications: ____________________________________
____
Do you follow a special diet? ❑Yes ❑No If yes, how would you describe your diet/how you eat? _________________
____
Tastes you tend to crave: ❑Bitter ❑Sweet ❑Pungent/Savory ❑Salty ❑Sour ❑Combination of Flavors/Textures: ______________________________ Foods you dislike/allergic to: ______________________________

Do you tend drink ❑Hot ❑Cold ❑Room Temperature food / fluids? Do you keep water by your bed? ❑Yes ❑No

Do you use any of the following?
Coffee, tea, soft drinks____ x/_____ dy/wk/mo ❑occasionally ❑none
Alcohol ____ x/_____ dy/wk/mo ❑occasionally ❑none Have you ever had a problem with *alcohol* or *alcoholism*? ❑No ❑Yes
Cigarettes, cigars, other tobacco ____ x/_____ dy/wk/mo ❑occasionally ❑none
Other drugs ❑occasionally ❑none Have you ever had a problem with *dependency* on other drugs? ❑No ❑Yes, ___________
What is your relationship with sugar? Describe: ____

Medical History

Please list hospital visits/stays, traumatic injuries, automobile accidents and surgeries with approximate dates: _________
____

Please check all that historically and currently apply. Circle choices where presented:

General	***Skin & Hair***	***Head & Neck***
❑Appetite good / fair / poor ❑Insomnia ❑Fatigue ❑Fevers / chills ❑Night sweats ❑Localized weakness ❑Poor Coordination ❑Bleed / bruise easily ❑Catch cold easily ❑Other: ____________________	❑Rashes / hives ❑Itching ❑Eczema ❑Pimples ❑Dryness ❑Herpes / shingles ❑Athlete's foot / warts ❑Other: ____________________	❑Dizziness ❑Fainting ❑Stiffness ❑Enlarged lymph glands ❑Headaches ❑Migraines ❑Concussions ❑Other: ____________________
Eyes ❑Blurred vision ❑Inflamed / dry eyes ❑Poor night vision ❑Spots / "floaters" ❑Cataracts ❑Glaucoma ❑Glasses / contacts ❑Other: ____________________	***Ears, Nose, Throat*** ❑Infection ❑Tinnitus "ringing" / "high tone / low tone" ❑Decreased hearing ❑Nose bleeds ❑Sinus infections ❑Hay fever / allergies ❑TMJ / jaw pain ❑Difficulty swallowing ❑Other: ____________________	***Cardiovascular & Circulatory*** ❑Low blood pressure ❑Blood clots ❑Palpatations "skip beats / flip flop" ❑Phlebitis ❑Chest pain ❑Irregular heartbeat ❑Cold hands / feet / both ❑Varicose veins ❑Lymphedema ❑Other: ___________________

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Respiratory	***Gastro-Intestinal***	***Male***
❑Asthma ❑Bronchitis ❑COPD ❑Pneumonia ❑Cough dry / productive ❑Coughing blood / blood streaked ❑Other: ______________________	❑Nausea ❑Belching / indigestion ❑Vomiting ❑Diarrhea / constipation ❑Stool with blood / black tarry ❑Bad breath ❑Rectal pain ❑Hemorrhoids bleeding / painful ❑Pain / cramps ❑Gall bladder disorder ❑Gas / bloating ❑Other: ______________________	❑Pain / itching genitalia ❑Hernia / lumps ❑Nocturnal / frequent urination ❑Weak urinary stream ❑Other: ______________________ ***Female*** ❑Pain / itching genitalia ❑Frequent urinary infection (UTI) ❑Frequent vaginal infection ❑Irregular menstrual cycle ❑Painful menstrual cycle ❑PMS ❑Menopausal syndrome ❑Hot flashes ❑Breast lumps ❑Other: ______________________
Neurological ❑Seizures ❑Tremors ❑Numbness / tingling of limbs ❑Concussion ❑Pain ❑Paralysis ❑Other: ______________________	***Psychological*** ❑Addiction ❑Depression ❑Stress / anxiousness ❑Irritability ❑Poor concentration ❑Therapy for: ❑Other: ______________________	***Muscular-Skeletal*** ❑Chronic pain ❑Stiff neck / shoulders ❑Low back pain ❑Back pain ❑Scoliosis ❑Muscle spasm / twitching / cramps ❑Sore, cold / weak knees ❑Joint pain ❑Tendon / Ligament strain / tears ❑Stress fracture / broken bones ❑Osteopenia / osteoporosis ❑Tendonitis / Bursitis ❑Other: ______________________

Other information you feel is important for me to know or we discussed: ____

____
____
____
____
____
____
____

SIGNATURE AND DATE

The aforementioned information is true and correct to the best of my knowledge. I will notify my practitioner of any changes that occur in my current health status.

Patient Signature: ____________________________________ Date: ____/____/____

Printed Name of Parent/Guardian: ____ Date: ____/____/____