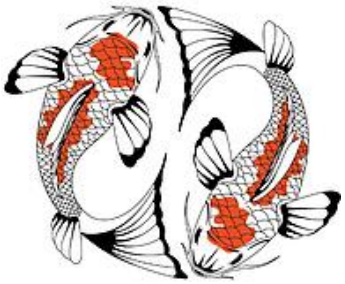

Soulqi

Acupuncture & Massage

ACUPUNCTURE

Health History Questionnaire

Please fill out this questionnaire to the best of your ability. Your answers will assist us in providing you with a complete evaluation. All answers will be held in absolute confidentiality. If you have any questions, please ask. If there is anything you wish to add that is not included in this questionnaire, please note it in the "Comments" section at the end. Thank you.

First Name:		Last Name:		Date of Birth:	
Address:		City:		State:	Postcode:
Home Phone:		Work Phone:		Mobile Phone:	
Age:	Gender: ☐ Male ☐ Female	Height:	Weight:	Marital Status: ☐ Married ☐ Single ☐ Defacto ☐ Divorced	
Occupation:					
Emergency Contact:		Relation to you:		Emergency Contact Number:	

Main condition you would like help with:

How long ago did this problem begin and how did it begin?

Have you been given a diagnosis for this condition and when?

What kind of treatment have you sought for this condition and when?

Is there anything else that you would like us to help you with?

Past personal medical history of significant illness (please tick all that apply):

☐ Asthma	☐ Stroke	☐ High blood pressure	☐ Clotting disorders
☐ Allergies	☐ Heart Disease	☐ Thyroid	☐ Other:
☐ Autoimmune	☐ Cancer	☐ Hepatitis	
☐ Diabetes	☐ Seizures	☐ Tuberculosis	

Hospitalisations/Surgeries (Please include dates):

Significant Trauma (Accidents, falls, head injuries etc. Please include dates) :

Allergies (Environmental, seasonal, chemical, medication):

Medication

Name	Dosage	Length of time taken	Reason for taking

What areas of your life are stressful? How does It affect your quality of life?

Do you have a regular exercise program?

☐ Yes

☐ No If yes, please describe:

Do you smoke?

☐ Yes If yes, how much a day?

☐ No How long have you been smoking?

How many caffeinated coffee, tea, or soft drinks do you drink per day/week?

How many glasses (250ml) water do you drink per day?

How many alcoholic beverages do you drink per day/week?

Please indicate any painful or distressed body areas:

Please tick boxes that apply to you, if you have had any of the following, particularly in the last three months

General:

☐ Fevers ☐ Chills ☐ Fatigue ☐ Sweat easily or profusely	☐ Poor sleeping ☐ Night sweats ☐ Cravings ☐ Change in appetite	Strong thirst for: ☐ Hot drinks ☐ Cold drinks ☐ Bleed or bruise easily ☐ Lack of taste or smell	☐ Peculiar taste or smell ☐ Unexplained weight loss or gain ☐ Sudden drop in energy, if so what time of the day?

Skin and Hair:

☐ Rashes ☐ Ulcerations ☐ Eczema ☐ Pimples	☐ Recent moles ☐ Psoriasis ☐ Hives ☐ Itching-night or day	☐ Change in hair or skin texture ☐ Dandruff ☐ Loss of hair ☐ Dermatitis	☐ Acne ☐ Rosacea ☐ Any other skin or hair problems of concern?

Head, Eyes, Ears, Nose, and Throat:

☐ Eye strain ☐ Blurry vision ☐ Poor vision ☐ Spots in field of vision ☐ Night blindness ☐ Sinus problems	☐ Glasses ☐ Eye pain ☐ Poor hearing ☐ Ringing in ears ☐ Recurrent sore throats ☐ Dizziness	☐ Concussions Nose bleeds ☐ Sores on lips or tongue ☐ Grinding teeth ☐ Migraines ☐ Facial pain ☐ Earaches	☐ Headaches, where and when?

Cardiovascular:

☐ High/low blood pressure ☐ Irregular heart beat ☐ Cold hands and feet ☐ Varicose or spider veins	☐ Chest pains ☐ Difficulty breathing ☐ Palpitations at rest ☐ Shortness of breath	☐ Fainting ☐ Blood clots ☐ Swelling of hands ☐ Swelling of feet	☐ Any other heart of blood vessel problems?

Respiratory:

☐ Cough ☐ Coughing blood ☐ Asthma	☐ Bronchitis ☐ Pneumonia ☐ Pain with deep breath	☐ Chest tightness ☐ Difficulty breathing when lying down	☐ Phlegm production: ☐ Nose/throat, what colour?

Gastrointestinal:

☐ Nausea ☐ Gas ☐ Indigestion ☐ Vomiting	☐ Constipation ☐ Belching ☐ Diarrhoea	☐ Excessive appetite ☐ Haemorrhoids ☐ Black stools ☐ Rectal pain	☐ Slow digestion ☐ Loose stools more than 2 per day Blood in stools	☐ Any other problems with stomach and intestines?

Dental:

☐ Bad breath ☐ Teeth problems ☐ Jack clicks	☐ Fillings ☐ Amalgam ☐ Bleeding gum

Genito-urinary:

☐ Bloating/oedema ☐ Acid reflex/GERD ☐ Hernia	☐ Poor appetite ☐ IBS/Crohn's Disease ☐ Colitis ☐ Abdominal pain/cramps	☐ Frequent urination ☐ Urgency to urinate ☐ Decrease in flow	☐ Any particular colour to your urine?

Male:

☐ Impotency ☐ Vasectomy ☐ Genital itching ☐ Erection difficulties	☐ Sores on genitals ☐ Kidney stones ☐ Incontinence ☐ Blood in urine	☐ Pain upon urination ☐ Unable to hold urine ☐ Genital pain, when and where?

Female:

Are you pregnant? ☐ Yes ☐ No	Is it possible that you could be pregnant? ☐ Yes ☐ No	Do you practice birth control? ☐ Yes ☐ No If yes, what type?	Number of pregnancies:
Live births:	Miscarriages:	Premature births:	Terminations:
Age at first menses:	Time period between menses:	Duration of menses:	Last PAP:

☐ Unusual character of blood(Heavy, Scanty): ☐ Irregular periods	☐ Pain periods ☐ Clots ☐ Breast lumps ☐ Genital itching ☐ Blood in urine	☐ Pain upon urination ☐ Incontinence ☐ Unable to hold urine ☐ Kidney stones	☐ Genital pain, where & when?
Musculoskeletal:			
☐ Neck pain ☐ Rotator cuff ☐ Knee pain ☐ Foot/ankle pain ☐ Muscle pain ☐ Hip pain	☐ Carpal tunnel Hand/wrist pain ☐ Sprains/strains Back pain: ☐ Lower ☐ Middle ☐ Upper	☐ Muscle spasm ☐ Muscle weakness ☐ Shoulder pain ☐ Sciatica ☐ Bursitis ☐ tendonitis	Soreness/weakness of the lower body(back, hip, knee, ankle, foot):
Neurological & Psychological:			
☐ Dizziness ☐ Concussion ☐ Depression	☐ Anxiety ☐ Nervousness ☐ ADD/ADHD	☐ Seizures ☐ Poor Memory ☐ Poor Coordination	☐ Bad temper ☐ Loss of balance ☐ Areas of numbness
☐ Anger ☐ Manic depression ☐ Easily susceptible to stress	Have you ever been treated for emotional problems? ☐ Yes ☐ No	Have you ever considered or attempted suicide? ☐ Yes ☐ No	Any other neurological or psychological issues?
Comments:			

Consent to Treatment

I, hereby authorise the acupuncturists &massage therapists at Soulqi to administer any style of oriental medicine relevant to my diagnosis and treatment, including but not limited to the following

Please read carefully and tick the boxes to acknowledge that you GIVE your consent for:

- ☐ Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
- ☐ Heat treatments using Artemisia vulgaris (moxibustion, “moxa”) or a conventional heat lamp. Indirect moxibustion treatments involve putting moxa on the head of the needle or the top of a barrier such as salt or a slice of ginger. When direct moxa is used, the moxa is placed directly on the skin. The heat generated from the moxa treatments may involve slight discomfort or leave a blister or scar on the skin. With any type of heat there is always a risk of a burn.
- ☐ A massage technique called “Gwa Sha”. This treatment leaves redness on the skin that can last 1-5days. Slight bruising and tenderness may persist after the treatment.
- ☐ Cupping may be used to promote circulate of Qi (energy) through the meridians. Cups may produce a red/purple colour on the area treated lasting anywhere from 1 to 7 days.
- ☐ Bloodletting, alone or in conjunction with cupping, maybe used to improve circulation in specific meridians. Lancets are inserted into the skin and a small amount of blood is expressed from the puncture.
- ☐ Tui Na, an Asian form of body massage meant to improve circulation and relax tension in muscles.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with this treatment, and have been given an opportunity to ask questions pertaining to the treatment. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

Printed Name of Patient

Patient Signature

Date: / /

Acupuncturist's Signature