Linda Lee Wellness: Informed Consent

Informed Consent for any Medical Massage, Acupuncture Integrating myofascial Release Treatment & Care

I hereby request and consent to be treated for the treatment of methods which may include, but are not limited to: Acupuncture, Dry needling, Medical Massage, Myofascial Release, Moxabustion, Gua Sha, (scrapping technique) Fire Cupping, Tui-Na, & E-Stim therapy. I understand that a $40.00 non-refundable deposit is required in order to reserve and book my session. All sessions that need to be rebooked needs to be within that week or for the following week from the day of your orginal appointment. All sessions rebooked further than one week will forfeit their deposit. Although the practitioner will make the recommended treatment plan and the necessary follow-up sessions during the initial consultation and assessment of the clients chief complaint, I understand that it is ultimately under the discretion of the patient to choose the type of session that he/she will receive as well as follow-up treatments.

I have been informed that acupuncture is a safe method of treatment in normalizing physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I understand that occasionally there may be some bruising that is caused from the cupping or tingling sensation from the acupuncture needles near the needling sites that last a few days. I understand that there have been very rare instances reported of fainting, infection and scarring and in extremely rare instances the report of spontaneous miscarriage and pneumothorax.

I understand that the recommendations that have been made are traditionally considered safe in the practice of Western and Chinese Medicine and any treatment received is a means of enhancing the overall health and wellbeing of the patient. I do not expect the acupuncturist/ massage therapist to be able to anticipate and explain all risks and complications. Therefore, I wish to rely on therapists' discretion to exercise judgment during the course of the procedure, which the acupuncturist feels at the time, based upon the facts then known, is in my best interests. By signing below, I agree to the above- named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

X_____ X_____

Print Name Date

Linda Lee LAc/LMT| 650 New Britain Ave,
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New Patient Information

Name_____Today's Date _____

Street Address _____ Unit_____

City_____State _____ Zip _____

Preferred Phone_____Email _____

Birth Date (include year)_____Age _____

Gender_____Height_____Weight _____

Occupation_____Employer _____

Marital Status_____Referred by _____

Emergency Contact: Name_____Phone_____

Primary Care Physician: Name_____Phone_____

Other Practitioners Involved In Your Care:

Name_____Phone_____

Name_____Phone _____

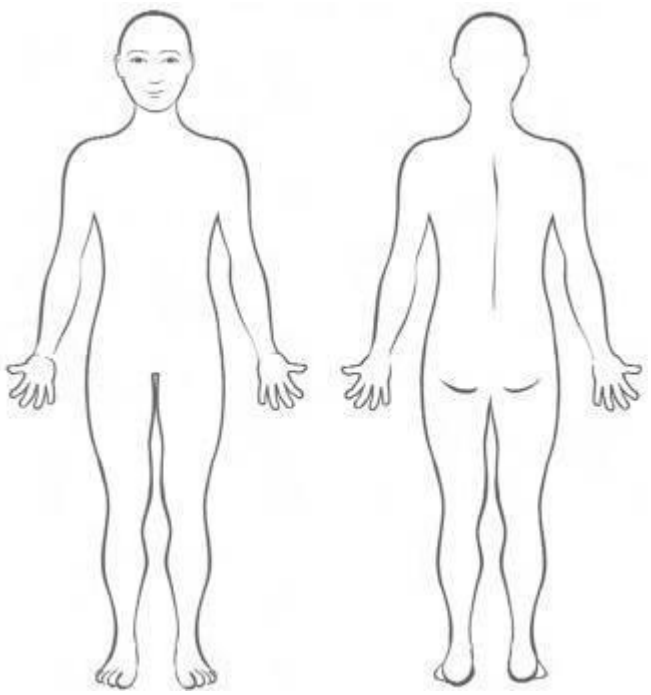
Health History:

Have you had acupuncture before?_____ If so, for what reason? _____

Main issue(s) you are seeking treatment for and length of time experiencing each: _____

Diagnoses from a medical professional and approximate dates of diagnosis (if applicable):

Please mark any areas of pain or discomfort:



Please list areas of pain or discomfort below with the 1-10 pain scale and a brief history:

(1: barely noticeable pain, 10: excruciating pain)

Please check any symptoms that you have experienced in the past or currently experience:

General

	past	current		past	current
sweating easily during the day	☐	☐	loss of appetite	☐	☐
weight loss/gain	☐	☐	increase in appetite	☐	☐
brain fog or confusion	☐	☐	trouble falling asleep	☐	☐
dizziness/vertigo	☐	☐	trouble staying asleep	☐	☐
fatigue during the day	☐	☐	swollen/sore lymph nodes	☐	☐
fevers	☐	☐	bleed or bruise easily	☐	☐
chills	☐	☐	autoimmune disease	☐	☐

Please elaborate:

Skin & Hair

	past	current		past	current
rashes/hives	☐	☐	psoriasis	☐	☐
eczema	☐	☐	itchy skin	☐	☐
dry skin	☐	☐	acne	☐	☐
oily skin	☐	☐	loss of hair/thinning hair	☐	☐

Please elaborate:

Head, Ears, Eyes, Nose & Throat

	past	current		past	current
earaches/pressure in the ears	☐	☐	headaches/migraines	☐	☐
ringing in the ears	☐	☐	sinus pressure	☐	☐
hearing loss	☐	☐	nose bleeds	☐	☐
eye floaters	☐	☐	dizziness/vertigo	☐	☐
itchy eyes	☐	☐	teeth/jaw clenching	☐	☐
blurry vision	☐	☐	sore throat	☐	☐
vision loss	☐	☐	swollen throat	☐	☐

Please elaborate:

Cardiovascular/Circulatory

	past	current		past	current
chest pain	☐	☐	swelling/edema	☐	☐
fainting	☐	☐	high blood pressure	☐	☐
lightheadedness	☐	☐	low blood pressure	☐	☐
cold hands & feet	☐	☐	palpitations	☐	☐
heart arrhythmia	☐	☐	heart murmur	☐	☐
shortness of breath	☐	☐			

Please elaborate:

Respiratory

	past	current		past	current
pain on inhaling	☐	☐	sneezing	☐	☐
chest tightness	☐	☐	seasonal/other allergies	☐	☐
cough	☐	☐	phlegm production	☐	☐
asthma	☐	☐	nasal congestion	☐	☐
wheezing	☐	☐	difficulty swallowing	☐	☐
pain behind the eyes	☐	☐			

Please elaborate:

Genito-Urinary

	past	current		past	current
difficulty urinating	☐	☐	urgent/frequent urination	☐	☐
blood in urine	☐	☐	sores on genitals	☐	☐
pain upon urination	☐	☐	genital pain	☐	☐
STD	☐	☐	yeast infections	☐	☐
bacterial vaginosis	☐	☐			

Please elaborate:

Neurological/Psychological

	past	current		past	current
anxiety	☐	☐	poor memory	☐	☐
depression	☐	☐	quick temper	☐	☐
loss of balance/coordination	☐	☐	easily susceptible to stress	☐	☐
areas of numbness/paralysis	☐	☐	mood swings	☐	☐
irritability	☐	☐	ADD/ADHD	☐	☐
Parkinsons	☐	☐	Multiple Sclerosis	☐	☐

Please elaborate:

Digestive

	past	current		past	current
heartburn	☐	☐	gas	☐	☐
belching	☐	☐	diarrhea	☐	☐
bloating	☐	☐	constipation	☐	☐
nausea	☐	☐	abdominal pain/cramps	☐	☐
vomiting	☐	☐	mucus in stool	☐	☐
chronic bad breath	☐	☐	blood in stool	☐	☐
sores on lips/tongue	☐	☐	hemorrhoids	☐	☐

Please elaborate:

For Women Only:

	past	current		past	current
irregular periods	☐	☐	breast pain	☐	☐
painful periods	☐	☐	vaginal discharge	☐	☐
bleeding between periods	☐	☐	vaginal sores	☐	☐
period clots	☐	☐	hot flashes	☐	☐
menstrual cramping	☐	☐	night sweating	☐	☐

age of first menses _____ duration of typical period _____

duration of typical cycle _____ date of last PAP _____

# of pregnancies _____ # of live births (+ years) _____

# of miscarriages _____ # of abortions _____

Are you currently pregnant orbreastfeeding? _____

Have you been through menopause? Age? _____

Did you experience a difficult menopause?

_____

_____

_____

_____

Have you ever taken birth control pills? When and for how long? _____

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

_____

_____

_____

Please elaborate on any of the above:

_____

_____

_____

_____

_____

For Men Only:

	past	current		past	current
erectile dysfunction/impotence	☐	☐	ejaculatory pain	☐	☐
varicocele	☐	☐	BPH	☐	☐

Please elaborate:

Lifestyle:

Current medications/herbs/supplements (please list dosages and how long you have been taking each):

Do you follow any certain diet or way of eating? (vegetarian, gluten-free, paleo, etc.)

How much water do you drink per day? Is it filtered and if so, which type of filter do you use?

Have you used antibiotics in the past? If so, when and how often?

Current exercise routine:

Do you or have you ever used tobacco? If so, how often?

Do you or have you ever drank alcohol heavily? If so, how many drinks/week?

Do you or have you ever taken recreational drugs? If so, how often?

Are you currently taking any of the following medications? *(circle if yes and indicate how often)*

Advil/Motrin/Ibuprofen	Aleve/Naproxen	Prednisone/Prednisolone
Celebrex/Celecoxib	Bayer/Aspirin	Acetaminophen/Tylenol

Allergies (medications/foods/chemicals/etc.):

Have you ever had a seizure? If yes, indicate date of last: _____

Please circle any significant illnesses and indicate date:

Cancer	Hepatitis	Diabetes
High blood pressure	Epilepsy	Heart Attack
Stroke	Ulcer Disease	Liver Disease
Colon Polyps	Other _____	

Please list any major surgeries/hospitalizations and approximate dates:

Family Medical History

□ Cancer □ Seizures □ High blood pressure □ Stroke □ Diabetes

□ Heart Attack □ Hepatitis □ Asthma □ Other _____

What are your goals for your health?

Please list any other relevant information or issues you would like to discuss: