David Engstrom **Body Therapy & Acupuncture**

3417 Evanston Avenue N. Suite 226 Seattle, WA 98103

Patient Information

Last Name: First Name: MI: ☐ M ☐ F

Phone Main: ( ) - Email:

Address: City: State: Zip:

Date of Birth: / / Age: Cell Phone: ( ) -

Work Phone: ( ) - Employer:

Spouse Name: Phone: ( ) -

Emergency Information

In case of Emergency please notify:

Name: Phone: ( ) - Relationship:

Office & Financial Policy

Thank you for choosing me as your health care provider. Please read each item carefully and initial where required.

· Payment

Insurance is not accepted. A coded superbill can be provided so that you may submit to your insuarnce carrier for reimbursement. Initial _______

Payment is due at time of service. Cash, checks, debit/credit, and HSA cards accepted.
Initial ________

· Office Policy

Our time together is valuable. To get the most out of your appointment, please do not bring children or guests with you to the session in order to minimize distractions. Initial _______

I am punctual about appointments and will expect that you will be as well. If you are running more than 15 minutes late, please call me at (206)938-0682. Clients will be charged in full for missed appointments or appointments cancelled less than 48 hours in advance. Initial _______

A legal guardian must accompany a minor (under 18 years) before treatment can be provided.

Referred By:

Patient Signature: Date Signed: / /

Name:_______________ DOB:_______________ Date:_______________

Primary Health Concerns

____

____

When did first notice your problem?_______________

How long have you had this problem? _______________

Has your problem been diagnosed by a physician? ☐ Yes ☐ No

What was the diagnosis and by who?_______________

What treatments have you tried?_______________

____

What makes it feel better?_______________

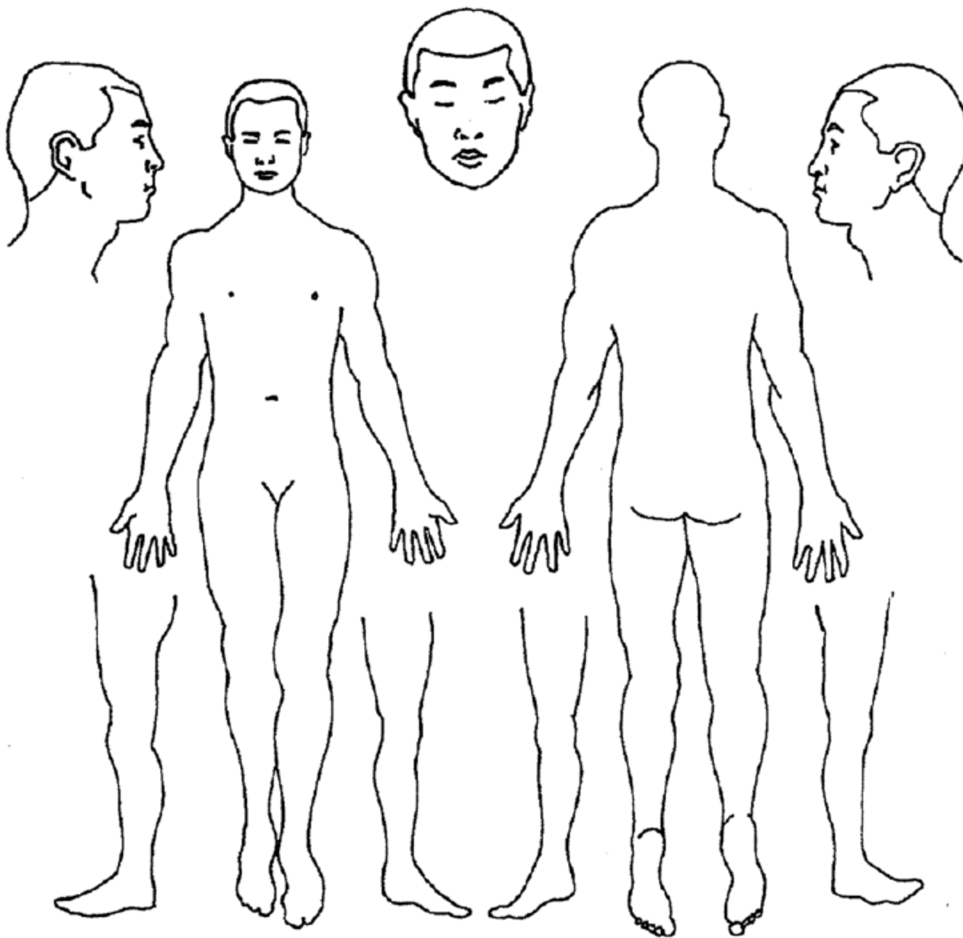
What makes it feel worse?_______________

Is there pain? ☐ Yes ☐ No Is your pain: ☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐ Throbbing ☐ Shooting ☐ Piercing ☐ Heavy ☐ Crushing ☐ Numbing ☐ Tingling ☐ Constant ☐ Intermittent

If you have pain please make a mark on the scale below to indicate the intensity of your pain:

0 _______________________________________ **10**

Please mark painful or distressed areas on the chart below with the symbol provided



Symbol	Reaction
Pain on Pressure	
x	Little
xx	Moderate
xxx	Strong
Swelling	
^	Slight
^^	Moderate
^^^	Severe
Tension/Weakness	
~	Tension
#	Weakness
Spontaneous Pain	
!	Slight
!!	Moderate
!!!	Severe
Pulsing	
0	Slight
00	Moderate
000	Strong
Temperature	
-	Colder
+	Hotter
Restricted Movement	
*	Little
**	Moderate
***	Severe

To what extent does your pain interfere with your daily activity?________________________________
Is your problem worse at different times of day or constant?

____
Are there other associated symptoms you experience with your issue?____________________________

____
Other health concerns:____

____

____
Personal health goals:____

____

Personal Medical History

☐ Alcoholism/Drug Addiction	☐ Digestive Issues / IBS	☐ Prostate Disease
☐ Allergies	☐ Endometriosis	☐ HIV/AIDS
☐ Arthritis	☐ Epilepsy	☐ Rheumatic Fever
☐ Asthma	☐ Gall Stones	☐ Seizure
☐ Cancer	☐ Heart Disease	☐ Stroke
☐ Candida/Yeast Infections	☐ High Blood Pressure	☐ Thyroid Disease
☐ Chronic Fatigue	☐ Hepatitis	☐ Urinary Infections
☐ Diabetes	☐ Kidney/Bladder Disease	☐ Venereal Disease

Other Illness:____
Surgeries(type, date)____

____

____
Accidents/Traumas:____

____

____
Dental Health:____
Allergies (drugs, chemical, foods, etc.)____

____

____
Medication History:

Present	Past		Present	Past		Present	Past	
☐	☐	Antibiotics	☐	☐	Cholesterol	☐	☐	Aspirin/Tylenol
☐	☐	Antidepressants	☐	☐	Prednisone	☐	☐	Pain Medication
☐	☐	Asthma/Allergy	☐	☐	Cortisone	☐	☐	Opiates
☐	☐	Antacids	☐	☐	Contraceptives	☐	☐	Laxatives
☐	☐	Anti-Anxiety	☐	☐	Hormones	☐	☐	Chemotherapy
☐	☐	Blood Sugar	☐	☐	Thyroid	☐	☐	Blood Pressure

Current Prescriptions:____

____

____
Vitamins and Herbs:____

____

____

Family History

	Father	Mother	Brother	Sister	Grandparent	Uncle/Aunt/Cousin
Alcohol/Drug Addiction	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Dementia/Alzheimer's	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Digestive / Bowel	☐	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Hepatitis Carrier	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Genetic Disorder	☐	☐	☐	☐	☐	☐
Age at Death	______	______	______	______		

Cause of Death ____

Lifestyle/Social History

Check if you eat, drink, or use regularly

- ☐ Alcohol
- ☐ Artificial Sweeteners
- ☐ Candy
- ☐ Carbonated beverages
- ☐ Cigarettes (packs/day)______
- ☐ Coffee/Tea/Caffeine
- ☐ Fast food
- ☐ Fried food
- ☐ Lunch meats
- ☐ Margarine/Vegetable Oils
- ☐ Nutritional supplements
- ☐ Organic foods
- ☐ Packaged foods
- ☐ Recreational drugs
- ☐ Refined flour (breads/pasta)
- ☐ Sugar
- ☐ Tobacco products

Check if you:

- ☐ Diet often
- ☐ Eat out often
- ☐ Exercise regularly
- ☐ Do not exercise regularly
- ☐ Work chemical or agricultural chem exposure (past included)
- ☐ Chemical exposure in leisure or hobby activities (past also)
- ☐ Live/work in a new structure
- ☐ Perm or dye your hair
- ☐ Under high stress work/home
- ☐ Live alone
- ☐ Have pets _______________
- ☐ Have a hobby
- ☐ Have a regular spiritual life
- ☐ Participate in social or church events
- ☐ Volunteer your time

Do you follow a special diet?____

List some of your favorite foods/flavors____

____

Are you satisfied with your current diet?____

____

Please describe your average daily food intake including times:

Morning:____

____

Afternoon:____

____

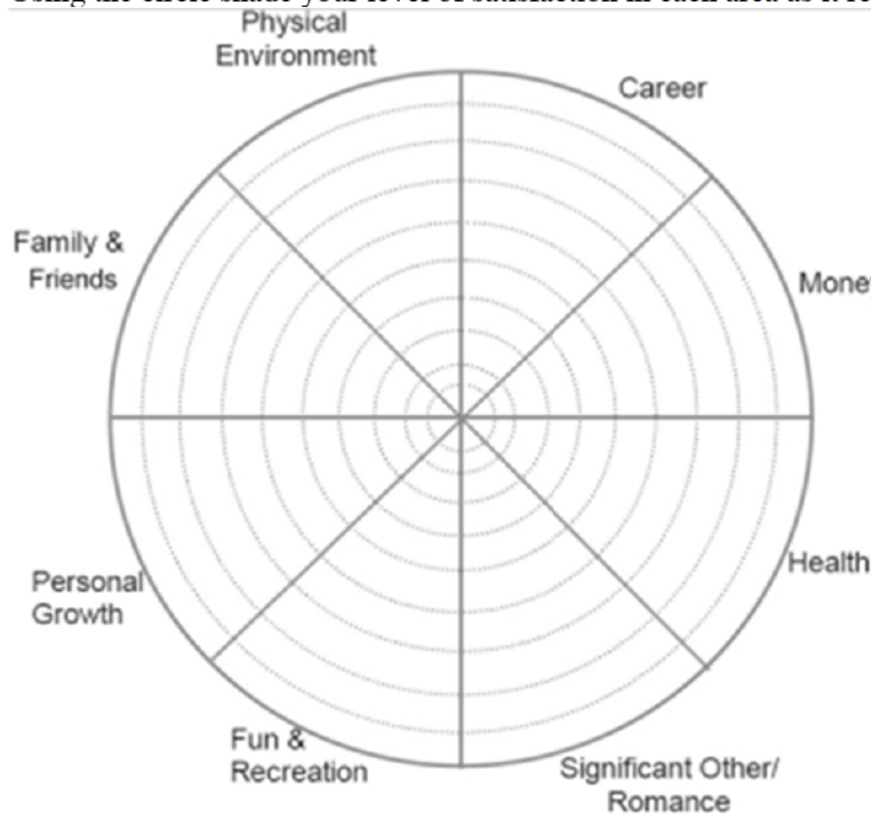
Evening:____

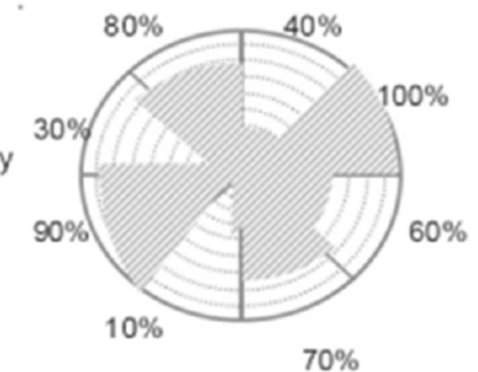
____

Eat on the go or sit down to a meal? ☐ Sit ☐ Go Do you eat when you're not hungry? ☐ Yes ☐ No
Do you snack? What do you snack on? ______________________________
Do you eat the same foods every day? ______________________________
How much water do you drink daily? ______________________________
How much coffee, tea, or soft drinks do you consume a day? ______________________________
How much alcohol do you consume a day? What kind?______________________________
If you smoke tobacco/marijuana how many years have you smoked? ______________________________
If you have quit smoking, when did you quit and how long did you smoke? ______________________________
What is you main employment activity? ______________________________
Do you enjoy your work?______________________________
How many hours a day do you spend at job related tasks? ______________________________
Are you married or have a committed relationship?______________________________
Do you have children, how old? ______________________________
What kind of exercise do you do? ______________________________
What leisure activities do you enjoy? ______________________________
What kind of spiritual activities do you practice?______________________________
Is your home: Check all that apply ☐Supportive ☐Comfortable/relaxing ☐Stressful ☐Lonely
Have you had any significant changes in your life recently?______________________________
____
____
____
How much sleep do you get:________ Do you have trouble sleeping, what happens?______________________________
____
____
____

Wheel of Balance

Using the circle shade your level of satisfaction in each area as it relates to you.





Review of Systems

Please check any conditions that you have experienced in the past six months

Skin and Hair

- ☐ Change in skin texture
- ☐ Dry
- ☐ Oily
- ☐ Itching
- ☐ Rashes/hives
- ☐ Eczema
- ☐ Flaking/dandruff
- ☐ Pimples
- ☐ Psoriasis
- ☐ Moist/clammy
- ☐ Moles
- ☐ Hair loss
- ☐ Sores/ulcers

Head, Ears, Eyes, Nose, Throat

- ☐ Dizziness
- ☐ Headaches
- ☐ Migraines
- ☐ Concussions
- ☐ Jaw pain/clicking
- ☐ Teeth grinding
- ☐ Facial pain
- ☐ Tooth pain/gum bleeding
- ☐ Sores on lips or in mouth
- ☐ Earaches
- ☐ Ringing in ears Loud/Soft
- ☐ Poor hearing
- ☐ Blurry vision
- ☐ Eye pain/strain
- ☐ Eye lid twitching
- ☐ Itchy eyes
- ☐ Spots in front of eyes
- ☐ Color blindness
- ☐ Glasses/contacts
- ☐ Night blindness
- ☐ Earaches
- ☐ Constant head colds
- ☐ Nasal stuffiness
- ☐ Sinus pain
- ☐ Nose bleeds
- ☐ Swollen glands
- ☐ Recurrent sore throats

Cardiovascular

- ☐ Blood clots
- ☐ Bruise easily
- ☐ Chest pain/pressure
- ☐ Dizziness
- ☐ Cold hands and feet
- ☐ Fainting
- ☐ Irregular heart beat
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Swelling hands or feet
- ☐ Pain or cramping in legs
- ☐ Varicose or spider veins

Respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ Frequent Cough
- ☐ Difficulty breathing
- ☐ Excessive phlegm

What color?___________________

- ☐ Frequent chest colds
- ☐ Pain with inhalation
- ☐ Pneumonia

Gastrointestinal

- ☐ Abdominal pain or cramps
- ☐ Nausea/Vomiting
- ☐ Bad Breath
- ☐ Black Stool
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas/Flatulence
- ☐ Indigestion
- ☐ Loose Stool
- ☐ Hemorrhoids
- ☐ Pain relieved by eating
- ☐ Undigested food in stool

Genitourinary

- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Urgency to urinate
- ☐ Kidney stones
- ☐ Pain/burning with urination
- ☐ Waking to urinate
- ☐ Venereal Disease

Male

- ☐ Difficulty with sexual function
- ☐ Sores or discharge
- ☐ Prostate cancer

Last Prostate Exam:_________________

Musculo/Skeletal

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Arm/Elbow/Wrist/Hand pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Hip pain
- ☐ Leg/Knee/Ankle/Foot pain
- ☐ Joint pain
- ☐ Muscle pain or soreness
- ☐ Stiffness AM/PM/Always
- ☐ Numbness/Tingle
- ☐ Shooting pains

Neuro/Psychological

- ☐ Anxiety
- ☐ Depression
- ☐ Easily stressed
- ☐ Bad temper
- ☐ Poor memory Long/Short term
- ☐ Poor balance
- ☐ Poor coordination
- ☐ Frequent headaches
- ☐ Numbness/Tingling
- ☐ Clumsiness

Endocrine

- ☐ Crave sugar
- ☐ Crave salt
- ☐ Weight gain/loss
- ☐ Constant appetite
- ☐ Frequent urination
- ☐ Fatigue
- ☐ Irritable/restless
- ☐ Night sweats
- ☐ Energy drops

Female

- ☐ Premenstrual changes
- ☐ Painful menses
- ☐ Menstrual clots
- ☐ Heavy flow
- ☐ Light flow
- ☐ Unusual menses
- ☐ Irregular menses
- ☐ Miscarriages ____________
- ☐ Abortions:______________
- ☐ Breast lumps
- ☐ Breast/uterine cancer
- ☐ Breast tenderness
- ☐ Nipple discharge
- ☐ Vaginal discharge
- ☐ Vaginal/Vulvar itching
- ☐ Vaginal sores
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Vaginal births:_____________
- ☐ Cesarean births:____________
- ☐ Still births:_______________

Female History

Age at first menses:________________	First day of last menses:____________	How long:________________________
Age at menopause:_________________	Number of pregnancies:_____________	Last PAP:________________________
Time between menses:______________	Birth Control: ☐ Yes ☐ No	Result:___________________________
Duration of menses:________________	What type:_______________________	☐ Maternal history of breast cancer

Any other gynecologic issues?____

____

Reviewed by: ____________________________________ Date:_____________________________

David Engstrom Body Therapy & Acupuncture
Patient Consent Form

I am a licensed Acupuncturist (AC00000138) and Licensed Massage Therapist (MA60026945) in the State of Washington. I am certified by the National Commission for the Certification of Acupuncturists as a Diplomate of Acupuncture and by the National Certification Board for Therapeutic Massage and Bodywork. I hold a Master's of Acupuncture degree from the Northwest Institute of Acupuncture and Oriental Medicine and a massage certificate from the Alexandar School of Natural Therapeutics.

Services Provided
The Following is a list of the services that I provide as a practitioner:

- Acupuncture: The insertion and manipulation of filiform needles into various points on the body to relieve pain
- Moxibustion: The warming of regions and acupuncture points by the burning of moxa with the intention of stimulating circulation through the points and inducing a smoother flow of blood and qi.
- Acupressure/Tui Na: The application of physical pressure to acupuncture points by the hand, elbow, or with various devices
- Bodywork (structural integration): A deep tissue and neuro-muscular re-education method
- Cupping: A form of traditional medicine found in many cultures worldwide that involves the placement of cups containing reduced air pressure (suction) on the skin
- Dermal Friction (Gua Sha): Repeated pressured strokes over lubricated skin with a smooth edge
- Diet and Chinese Herbal Medicine advice based on Traditional Chinese Medicine Theory

Additional Information
Side effects may include, but are not limited to, the following: some pain in the insertion area following treatment, minor bruising, infection, and light-headedness.

Patients with severe bleeding disorders or pacemakers should inform me of this prior to any treatment. Disposable, pre-sterilized needles are utilized in the office. Needles are used once and then discarded as a safeguard to the patient's health.

If you have any questions or concerns, please discuss with me prior to signing this document.

Patient/Guardian Signature:____**Date:**__________

David Engstrom Body Therapy & Acupuncture
3417 Evanston Ave N, Suite 226
Seattle WA 98103
(206) 938-0682

DAVID ENGSTROM BODY THERAPY & ACUPUNCTURE
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Seattle WA 98103
(206) 938-0682

NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting David Engstrom, at (206)938-0682.

☐ I agree that David Engstrom may contact me via unsecured email and text for appointment reminders: ☐Text ☐Email

☐ I agree that David Engstrom may contact me via unsecured email or text with information related to my healthcare: ☐Text ☐Email

☐ I wish to be contacted by David Engstrom via secured email or text messaging only: ☐Text ☐Email

☐ I do not wish to be contacted whatsoever via email or text by David Engstrom: ☐Text ☐Email

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

___________________________________	___________________________________
Patient or legally authorized individual signature	Date Time
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record.

Consent for Use of Photography and Video for Medical Treatment

Purpose

The use of patient photography, video, digital images, and other visual recordings during client care will assist in documenting your care and the efficacy of your treatment regimen. Such visual images will be used for the sole purpose of tracking your progress.

Procedure

A dedicated camera will be used to record the session. Images will be printed and placed in your medical record or downloaded to a computer file within a secure cloud based network or external drive device.

Information that identifies your name, address, telephone number, date of birth, and insurance information will be kept secure.

Expiration

Files at David Engstrom Body Therapy & Acupuncture are kept for seven (7) years. After seven (7) years, all digital and printed files will be destroyed. If you wish to revoke this consent before seven (7) years, the revocation must be in writing and delivered to:

David Engstrom Body Therapy & Acupuncture
3417 Evanston Avenue North, Suite 226
Seattle WA 98103

Upon the expiration of this consent, all printed and digital images will be destroyed.

Form continues on back >

Consent for Use of Photography and Video for Medical Treatment

I hereby give consent to David Engstrom Body Therapy & Acupuncture to provide care that involves therapeutic treatments considered advisable in the judgment of the attending provider.

I understand that video recordings, photographs, or digital images may be used to document my care and be included in my medical record, and I consent to this. I understand that these images will be stored securely and that my privacy will be protected. The images that identify me will only be released upon written authorization by me or my legal representative.

I understand I may refuse to sign this consent and, if I have signed, I am free to withdraw at any time. My refusal will not affect my ability to obtain treatment.

If I want the visual images for my own use, a copy may be provided at my cost. The originals will be kept by David Engstrom Body Therapy & Acupuncture.

I am 18 years or older, and warrant that I have read this **Consent for Use of Photography and Video for Medical Treatment.**

I understand it, and I freely enter into this agreement. I hereby hold harmless David Engstrom Body Therapy & Acupuncture and its employees, agents, and affiliates from any and all liability that arises from this Consent.

To rescind this Consent, I must do so in writing to the address below.

I have been given a copy of this Consent.

Signature: ______________________________

Printed Name: ______________________________

Date: ____________________

If signed by someone other than patient, indicate relationship: ______________________________

Contact Information:

Mailing Address: ______________________________

____

Phone Number: ______________________________

Email Address: ______________________________

For questions or concerns, contact David Engstrom at:

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david@davidengstrom.net