Lotus Hands Acupuncture
& Herbal Medicine, LLC

Patient Intake Form

Welcome to Lotus Hands Acupuncture & Herbal Medicine. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name		Sex ☐F ☐M	Date
Date of birth	Age	Occupation	
Main phone number		Other phone number	
E-mail address		Allow email contact by LHAHM ☐Yes ☐No	
Emergency contact name & phone		Marital status	# of children
Address: Street		City State	Zip
Family physician	Chiropractor		

How did you find out about our clinic? ☐ *Friends/Relatives (name)* _____

☐ *Location or walk by* ☐*Website* ☐*Referred by* _____

☐ *Periodicals* ☐*Other (please specify)* _____

Main problem(s): _____

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____ What are the causes of this problem? _____

What kind of treatment have you tried? _____

What makes this problem worse? _____ What makes this problem better? _____

Medical History: Check any condition that you have or currently experiencing: **P=Past | C=Current | F=Family**

Diagnosis	P	C	F	Diagnosis	P	C	F	Diagnosis	P	C	F	Diagnosis	P	C	F
Cancer	☐	☐	☐	Nervous Disorder	☐	☐	☐	Tuberculosis	☐	☐	☐	Jaundice	☐	☐	☐
Diabetes I/II	☐	☐	☐	Heart disease	☐	☐	☐	High cholesterol	☐	☐	☐	Kidney disease	☐	☐	☐
Hepatitis	☐	☐	☐	Digestive disorders	☐	☐	☐	High blood pressure	☐	☐	☐	Liver disease	☐	☐	☐
Anemia	☐	☐	☐	Venereal disease	☐	☐	☐	Emotional disorders	☐	☐	☐	Migraines	☐	☐	☐
Seizures	☐	☐	☐	Alcoholism	☐	☐	☐	Blood transfusion	☐	☐	☐	Vein Condition	☐	☐	☐
Arthritis	☐	☐	☐	Depression or anxiety	☐	☐	☐	Epilepsy/Seizures	☐	☐	☐	Pneumonia	☐	☐	☐
Asthma	☐	☐	☐	Thyroid disease	☐	☐	☐	Glaucoma	☐	☐	☐	Stroke	☐	☐	☐
COPD	☐	☐	☐	Pace makers/implants	☐	☐	☐	Post-stroke	☐	☐	☐	Hemophiliac	☐	☐	☐
HIV	☐	☐	☐	Auto Immune	☐	☐	☐	Heavy Bleeding	☐	☐	☐	MS/Parkinson	☐	☐	☐

Medicines: Prescriptions, over-the-counter (OTC) medications and supplements you are currently taking:

Medication or Supplement	For what condition?	Medication or Supplement	For what condition?

Surgeries: _____ **Hospitalization:** _____

Significant trauma: (auto accidents, sports injuries, etc): _____

Allergies: (drugs, chemicals, foods, environmental): _____

Do you have a history of frequent antibiotic use? _____

Occupation: _____ Do you usually work ☐ Indoors? ☐ Outdoors?

Occupational stress (chemical, physical, psychological, etc): _____

Personal: Height: _____ Weight now: _____ Weight last year: _____ Weight max: _____ @Year:_____

Lifestyles: Do you smoke? ☐Yes ☐No What? _____ How many per day? _____ Since when? _____

Do you exercise regularly? ☐Yes ☐No Please describe your exercise program: _____

Do you travel frequently? ☐Yes ☐No Have you traveled overseas to 'developing' countries? ☐Yes ☐No

Sleep: How many hours do you sleep in general? _____ What time do you usually go to bed? _____

I have difficulties with (*check all that apply*): ☐falling asleep ☐ staying asleep ☐ dream disturbed sleep ☐ racing mind

Do you often experience waking up and not being able to fall asleep again? ☐Yes ☐No at _____ ☐AM ☐PM

Number of times per night you get up to use restroom? _____

Diet: Coffee _____ cups/day Colas _____ can(s)/day Tea _____ cups/day Wine or beer/week? _____

How much water do you drink per day? _____

Are you a vegetarian? ☐Yes ☐No ☐ Yes, but not so strict Do you eat a lot of spicy food? ☐Yes ☐ No

Please describe your average daily diet (Please be as specific as possible):

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Please list some of your favorite foods: _____

Check all the foods/flavors you enjoy and eat often:

☐Spicy ☐Sweet ☐Salty ☐Bitter ☐Sour ☐Fresh/raw foods ☐Fried foods ☐Dairy ☐Canned foods

☐Fast-food ☐Sodas ☐Coffee ☐Red meat ☐White meat ☐Frozen foods/microwave meals

Indicate painful or distressed areas: *(see picture in the next page)*

How would you characterize your pain (*check all that apply*): ☐Dull/achy ☐Sharp/stabbing ☐Burning ☐Tingling

☐Numbness ☐Electrical ☐Superficial ☐Deep ☐Shooting

The pain is (*check all that apply*): ☐Better/☐worse with heat ☐Better/☐worse with cold ☐Better/☐worse with pressure

☐Better/ ☐worse with movement ☐Better/ ☐worse with rest Worse in ☐AM/ ☐PM

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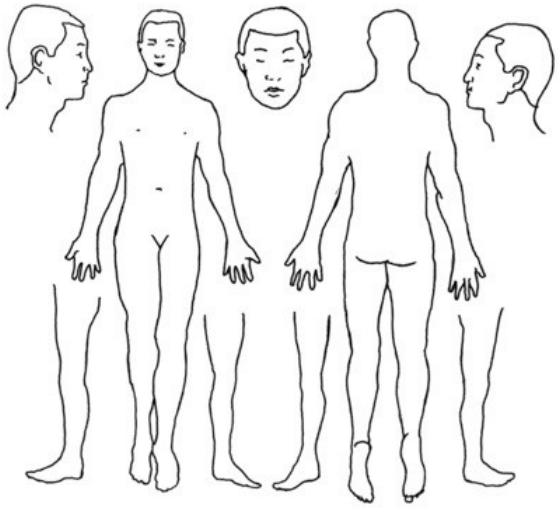

Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General: ☐Poor appetite ☐Poor sleep ☐Fatigue ☐Fevers ☐Chills
☐Night sweats ☐Sweat easily ☐Tremors ☐Cravings ☐Change in appetite
☐Poor balance ☐Bleed or bruise easily ☐Localized weakness ☐Weight loss ☐Weight gain
☐Peculiar tastes ☐Desire hot food ☐Desire cold food ☐Strong thirst (cold or hot drinks)
☐Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____

Skin & hair: ☐Rashes ☐Ulcerations ☐Hives ☐Itching ☐Eczema
☐Pimples ☐Acne ☐Dandruff ☐Dry skin ☐Recent moles ☐Loss of hair
☐Purpura ☐Change in hair or skin texture ☐Other? _____

Musculoskeletal: ☐Joint disorders ☐Muscle weakness ☐Pain/soreness in the muscles
☐Cold hands/feet ☐Difficulty walking ☐Swelling of hands/feet ☐Spinal curvature ☐Hand/wrist pain
☐Hernia ☐Numbness ☐Tingling ☐Paralysis ☐Neck pain ☐Neck tightness
☐Shoulder pain ☐Back pain ☐Hip pain ☐Knee pain ☐Joint sprain ☐Tremors ☐Other? _____

Head, eyes, ears, nose, & throat: ☐Dizziness ☐Concussions ☐Migraines ☐Eye strain
☐Glasses/lens ☐Eye pain ☐Color blindness ☐Night blindness ☐Poor vision ☐Cataracts ☐Earaches
☐Blurry vision ☐Ringing in ears ☐Poor hearing ☐Spots in front of eyes ☐Sinus problems ☐Sore throat
☐Nose bleeding ☐Grinding teeth ☐Teeth problems ☐Facial pain ☐Jaw clicks ☐Sores on lips/tongue
☐Difficulty swallowing ☐Other? _____

Cardiovascular: ☐High blood pressure ☐Low blood pressure ☐Chest pain ☐Palpitation
☐Fainting ☐Phlebitis ☐Irregular heartbeat ☐Rapid heartbeat ☐Varicose veins ☐Other? _____

Respiratory: ☐Cough ☐Coughing blood ☐Wheezing ☐Difficulty breathing
☐Bronchitis ☐Pneumonia ☐Chest pain ☐Production of phlegm (What color?) _____

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Gastrointestinal: ☐Nausea ☐Vomiting ☐ Diarrhea ☐Constipation ☐Gas
☐Belching ☐Black stools ☐Blood in stools ☐Indigestion ☐Bad breath ☐Rectal pain
☐Hemorrhoids ☐Abdominal pain/cramps ☐Gallbladder problems ☐Parasites ☐Chronic laxative use

Bowel movements: Frequency _____ Color _____ Odor _____ Texture/Form _____

Neuro-psychological: ☐Loss of balance ☐ Lack of coordination ☐Concussion
☐Depression ☐Anxiety ☐ Stress ☐Bad temper ☐Bi-polar

Genito-urinary: ☐Painful urination ☐Frequent urination ☐Blood in urine ☐Urgency to urinate
☐Kidney stones ☐Unable to hold urine ☐Pause of flow ☐Dribbling ☐Frequent urinary tract infection
☐Genital pain ☐Genital itching ☐Genital rashes ☐STD ☐Other?

Female: ☐Frequent vaginal infections ☐Pelvic infection ☐Endometriosis
☐Vaginal/genital discharge ☐Fibroids ☐Irregular periods ☐Clots
☐Pain/cramps prior/during periods ☐Breast tenderness ☐Breast Lumps ☐Fertility Problems
☐Hot flashes ☐Moodiness related to periods ☐Ovarian cysts

_____ Number of pregnancies _____ Number of births _____ Number of miscarriages _____ Number of abortions
_____ Number of premature births _____ Number of C-sections _____ Number of difficult deliveries

First date of last period _____ Age of first period _____

Duration of periods ____ days, Cycle ____ days Flow: ☐heavy ☐light ☐spotting ☐no flow
Do you practice birth control ? ☐Yes ☐No

If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long? _____

Male:
☐Prostate problems ☐Discharge ☐Erectile dysfunction ☐Ejaculation problems
☐Frequent seminal emission ☐Fertility problems ☐Painful/swollen testicles ☐Other? _____

☐I have completed this form correctly to the best of my knowledge.

Are there any other health issues you want to discuss with us?

Signature: _____ ☐Adult Patient ☐Parent or Guardian ☐Spouse

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Informed Consent to Oriental Medical Healthcare

I, _____ , hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physiotherapy on me (or on the patient named below, for whom I am legally responsible) by the licensed acupuncturists at the Lotus Hands Acupuncture & Herbal Medicine.

I understand that methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, moving cupping, electrical stimulation, Tui-Na (Chinese Massage), the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels at the time, based upon the facts they known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

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.

PAYMENT

We request payment at the time of services rendered. Prepaid Treatment Package (PTP) will be required for future visits that need to be paid on your first PTP's session. Should you discontinue care or be released from further service at our office, all outstanding balances will be due. Please note, PTP are valid for 2 months or 4 months (package of 5 or 10 treatments) from the date purchased. No refunds will be made if your package is expired. Our office only accepts cash, check and all major credit cards.

I understand that Lotus Hands Acupuncture reserve the right to charge me $40 for cancellations made less than one business day before the appointment time. No Shows pay full cost of missed appointments. There is a $25 fee for all returned checks. Payment is due at time of service.

_____ _____

Patient's Signature Date