

## 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 <input type="checkbox"/> F <input type="checkbox"/> M	Date
Date of birth	Age	Occupation
Main phone number	Other phone number	
E-mail address	Allow email contact by LHAHM <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Friends/Relatives (name) _____		
<input type="checkbox"/> Location or walk by <input type="checkbox"/> Website <input type="checkbox"/> Referred by _____		
<input type="checkbox"/> Periodicals <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes I/II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digestive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vein Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pace makers/implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophiliac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Auto Immune	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heavy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MS/Parkinson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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

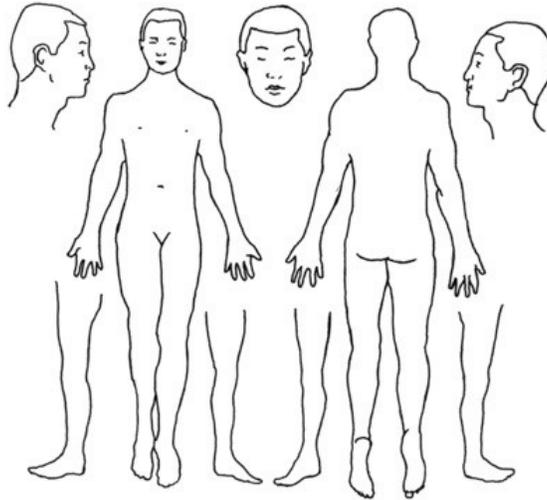
**Indicate painful or distressed areas:** (*see picture in the next page*)

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



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

- General:**
- |                                          |                                                 |                                             |                                                             |                                             |
|------------------------------------------|-------------------------------------------------|---------------------------------------------|-------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Poor appetite   | <input type="checkbox"/> Poor sleep             | <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Fevers                             | <input type="checkbox"/> Chills             |
| <input type="checkbox"/> Night sweats    | <input type="checkbox"/> Sweat easily           | <input type="checkbox"/> Tremors            | <input type="checkbox"/> Cravings                           | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Poor balance    | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Weight loss                        | <input type="checkbox"/> Weight gain        |
| <input type="checkbox"/> Peculiar tastes | <input type="checkbox"/> Desire hot food        | <input type="checkbox"/> Desire cold food   | <input type="checkbox"/> Strong thirst (cold or hot drinks) |                                             |
- Sudden energy drop (What time of day) \_\_\_\_\_ Favorite time of year \_\_\_\_\_ Worst time of year \_\_\_\_\_

- Skin & hair:**
- |                                  |                                                         |                                       |                                   |                                       |
|----------------------------------|---------------------------------------------------------|---------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes  | <input type="checkbox"/> Ulcerations                    | <input type="checkbox"/> Hives        | <input type="checkbox"/> Itching  | <input type="checkbox"/> Eczema       |
| <input type="checkbox"/> Pimples | <input type="checkbox"/> Acne                           | <input type="checkbox"/> Dandruff     | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Purpura | <input type="checkbox"/> Change in hair or skin texture | <input type="checkbox"/> Other? _____ |                                   |                                       |

- Musculoskeletal:**
- |                                          |                                             |                                                       |                                           |                                          |
|------------------------------------------|---------------------------------------------|-------------------------------------------------------|-------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Joint disorders | <input type="checkbox"/> Muscle weakness    | <input type="checkbox"/> Pain/soreness in the muscles |                                           |                                          |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Swelling of hands/feet       | <input type="checkbox"/> Spinal curvature | <input type="checkbox"/> Hand/wrist pain |
| <input type="checkbox"/> Hernia          | <input type="checkbox"/> Numbness           | <input type="checkbox"/> Tingling                     | <input type="checkbox"/> Paralysis        | <input type="checkbox"/> Neck pain       |
| <input type="checkbox"/> Neck tightness  | <input type="checkbox"/> Shoulder pain      | <input type="checkbox"/> Back pain                    | <input type="checkbox"/> Hip pain         | <input type="checkbox"/> Knee pain       |
| <input type="checkbox"/> Joint sprain    | <input type="checkbox"/> Tremors            | <input type="checkbox"/> Other? _____                 |                                           |                                          |

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

- Cardiovascular:**
- |                                              |                                             |                                              |                                          |
|----------------------------------------------|---------------------------------------------|----------------------------------------------|------------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Palpitation     |
| <input type="checkbox"/> Fainting            | <input type="checkbox"/> Phlebitis          | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Rapid heartbeat |
| <input type="checkbox"/> Varicose veins      | <input type="checkbox"/> Other? _____       |                                              |                                          |

- Respiratory:**
- |                                     |                                         |                                     |                                                                   |
|-------------------------------------|-----------------------------------------|-------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Cough      | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Wheezing   | <input type="checkbox"/> Difficulty breathing                     |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia      | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Production of phlegm (What color?) _____ |



- 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

## **Informed Consent to Eastern 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 know, 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