

Blossoming Lotus Acupuncture

New Patient Information Form

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you. All information is confidential.

Name: _____ Sex: F M Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: Home: _____ Cell: _____ Work: _____

Email address: _____

Date of Birth: _____ Place of Birth: _____ Age: _____

Height: _____ Weight: _____ Circle one: Single Married Divorced Widowed Living with _____

Education: _____ Occupation: _____

Referred by: _____

Reason for visit today: _____

How long have you had this condition? _____

Have you ever experienced this before? _____

What seems to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it affect your: Sleep: _____ Work: _____ Emotions: _____ Other: _____

Other concerns (in order of priority): _____

Have you been treated with acupuncture or Chinese medicine before? Yes No

Are you under the care of a physician now? Yes: _____ No: _____ If yes, for what? _____

Physician's name: _____ Physician's number: _____

Other concurrent therapies: _____

In the case of emergency:

Contact: _____ Phone: _____ Relationship: _____

Medical Insurance Status: Self: _____ Private Insurance: _____ Worker's Comp: _____ Other: _____

Family Medical History – Please put an “X” in appropriate box(es).

	Self	Mother	Father	Sibling	Spouse	Children
Cancer or tumors						
Diabetes (please indicate type I or II)						
Blood or bleeding disorders/anemia						
Seizures						
Hypertension						
Coronary Artery Disease						
Elevated cholesterol levels						
Stroke						
Allergies						
Arthritis						
Asthma						
Depression or mental illness						
Hepatitis (please indicate A, B or C)						
Kidney disorders						
Thyroid disorders						
Musculoskeletal disorder						
Suicide						
Alcohol abuse						
Drug abuse						
Blood transfusion (if before 1985)						
Age of death						

Hospitalizations:

Year	Operation/Illness

Please list any medications you are currently taking, along with doses and the reason you are taking them:

Medications	Reason	Date began	Dose	Helps?Y/N

Please indicate with “C” for current condition, and “P” for past conditions:

<p>General Symptoms</p> <p><input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> Heavy appetite</p> <p><input type="checkbox"/> Strongly like cold drinks</p> <p><input type="checkbox"/> Strongly like hot drinks</p> <p><input type="checkbox"/> Recent weight loss/gain</p> <p><input type="checkbox"/> Poor sleep</p> <p><input type="checkbox"/> Heavy sleep</p> <p><input type="checkbox"/> Dream-disturbed sleep</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Lack of strength</p> <p><input type="checkbox"/> Bodily heaviness</p> <p><input type="checkbox"/> Cold hand or feet</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Sweat easily</p> <p><input type="checkbox"/> Muscle cramps</p> <p><input type="checkbox"/> Vertigo or dizziness</p> <p>Head & neck</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Migraines</p> <p><input type="checkbox"/> Concussions</p> <p><input type="checkbox"/> Stiff neck</p> <p><input type="checkbox"/> Swollen glands</p> <p><input type="checkbox"/> Enlarged thyroid</p> <p>Ears</p> <p><input type="checkbox"/> Ringing</p> <p><input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/> Infections</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Hearing Aids</p> <p>Eyes</p> <p><input type="checkbox"/> Glasses/contact lens (what age)</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Poor night vision</p> <p><input type="checkbox"/> Floaters</p> <p><input type="checkbox"/> Itchy eyes</p> <p><input type="checkbox"/> Red eyes</p> <p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Cataract</p> <p><input type="checkbox"/> Glaucoma</p> <p>Nose, Throat & Mouth</p> <p><input type="checkbox"/> Sinus infection</p> <p><input type="checkbox"/> Nosebleed</p> <p><input type="checkbox"/> Nasal congestion</p> <p><input type="checkbox"/> Hay fever/allergies</p> <p><input type="checkbox"/> Dry nose</p>	<p><input type="checkbox"/> Frequent sore throat</p> <p><input type="checkbox"/> Lumps in throat</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Mouth & tongue ulcers</p> <p><input type="checkbox"/> Gum problems</p> <p><input type="checkbox"/> Dry mouth</p> <p><input type="checkbox"/> Thirst</p> <p><input type="checkbox"/> Facial pain</p> <p><input type="checkbox"/> TMJ</p> <p><input type="checkbox"/> Loss of voice</p> <p><input type="checkbox"/> Excessive phlegm</p> <p>Respiratory</p> <p><input type="checkbox"/> Difficulty breathing</p> <p><input type="checkbox"/> Difficulty breathing when lying down</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Chest tightness</p> <p><input type="checkbox"/> Wet cough</p> <p><input type="checkbox"/> Dry cough</p> <p><input type="checkbox"/> Coughing up phlegm</p> <p><input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> Pneumonia</p> <p>Cardiovascular</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Palpitation</p> <p><input type="checkbox"/> Rapid heartbeat</p> <p><input type="checkbox"/> Irregular heartbeat</p> <p><input type="checkbox"/> Blood clots</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Difficulty breathing</p> <p><input type="checkbox"/> Swollen ankles</p> <p><input type="checkbox"/> Phlebitis</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> History of heart attack</p> <p>Gastrointestinal</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Acid regurgitation</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Hiccup</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Bad breath</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Bloody stools (what color?)</p> <p><input type="checkbox"/> Mucous in stool</p>	<p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Itchy anus</p> <p><input type="checkbox"/> Intestinal pain</p> <p><input type="checkbox"/> Anal fissures</p> <p><input type="checkbox"/> Laxative. What kind? How often?</p> <p><input type="checkbox"/> Gall bladder disorder</p> <p>Musculoskeletal</p> <p><input type="checkbox"/> Neck/shoulder pain</p> <p><input type="checkbox"/> Muscle pain</p> <p><input type="checkbox"/> Upper back pain</p> <p><input type="checkbox"/> Low back pain</p> <p><input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Rib pain</p> <p><input type="checkbox"/> Limited range of motion</p> <p><input type="checkbox"/> Limited use</p> <p>Other: _____</p> <p>Skin & Hair</p> <p><input type="checkbox"/> Rashes</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Ulcerations</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> Acne</p> <p><input type="checkbox"/> Dandruff</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Hair loss</p> <p><input type="checkbox"/> Change in hair/skin texture</p> <p><input type="checkbox"/> Fungal infections</p> <p>Other: _____</p> <p>Neurological</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Tremors</p> <p><input type="checkbox"/> Numbness or tingling</p> <p><input type="checkbox"/> Poor memory</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Poor coordination</p> <p><input type="checkbox"/> Paralysis</p> <p>Other: _____</p> <p>Genitourinary</p> <p><input type="checkbox"/> Pain on urination</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Urgent urination</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Unable to hold urine</p> <p><input type="checkbox"/> Incomplete urination</p> <p><input type="checkbox"/> Bed wetting</p> <p><input type="checkbox"/> Wake to urinate</p>
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<input type="checkbox"/> Increased libido <input type="checkbox"/> Decrease libido <input type="checkbox"/> Kidney stone <input type="checkbox"/> Impotence <input type="checkbox"/> Premature ejaculation <input type="checkbox"/> Nocturnal emission	Infection Screening <input type="checkbox"/> HIV risks: self or partner <input type="checkbox"/> TB: self or household <input type="checkbox"/> Hepatitis risk: self or partner <input type="checkbox"/> History of sexually transmitted disease: self or partner	<input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Syphilis <input type="checkbox"/> Genital warts <input type="checkbox"/> Herpes: oral/genital
Other: 		

Personal Lifestyle:

Diet on a typical day:

Do you typically eat 3 meals a day? If no, how many: _____

If yes, please answer the following (1 – 3):

1) Breakfast: _____

2) Lunch: _____

3) Dinner: _____

Snacks: _____

Dietary restrictions: _____

Food cravings: _____

Supplements: _____

Exercise routine: _____

Spiritual practice: _____

Television habits: _____ Reading habits: _____

Interests and hobbies: _____

Cigarettes: _____ pack/_____ day Coffee/Tea: _____ cups Alcohol: _____ glasses/week

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Other recreational drugs: _____

Have you experienced any major traumas? Y N Explain: _____

Sources of support: _____ Coping Style: _____

Male Reproductive (Please indicate with "C" for current condition, and "P" for past conditions):

___ Sexual Difficulties ___ Prostrate Problems ___ Testicular Pain/Swelling ___ Penile Discharge

Female Reproductive:

Age of first menses: ___ Date of last menstrual period: ___ Duration of flow: ___

Blood clots: Yes No If yes, when: _____

Length of cycle: _____ Amount: _____

Color of menstrual blood (please circle): Pale Bright red Dark red Brown Other: _____

Texture of menstrual blood (please circle): Thick Thin Watery Normal

Pain: Yes No If yes: Location: _____ When: _____ Duration: _____

Irregular periods (describe) : _____

PMS (describe) : _____

Current method of contraception: _____ Past method(s) of contraception: _____

Are you currently pregnant: Yes No If yes, how long: _____

Number of:

Pregnancies: ___ Live births: ___ Miscarriages: ___ Abortions: ___ Premature births: _____

Breast (Lumps, Cysts, Tenderness, Nipple discharges etc.): _____

Urinary tract infections: _____ How frequent: _____

Vaginal discharges (describe color, texture, smell, frequency, etc.) : _____

Vaginal infections (please describe): _____

Pain/itching of genitalia: _____

PAP smear: Normal Abnormal Date of last PAP smear: _____

Uterine fibroids: _____ Endometriosis: _____ Other: _____

Menopause (date of onset): _____ Symptoms: _____

Any bleeding since? Yes No If yes, please explain: _____

Are you currently on Hormone Replacement Therapy (HRT)? Yes No If yes, what is the dosage: _____

How long have you been on HRT: _____ Any side effects: _____

Other:

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Consent to Treatment Form

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by the Licensed Acupuncturist named below. I have discussed the nature and purpose of my treatment with the Licensed Acupuncturist.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Chinese Medical Clinic as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

HERBAL FORMULAS AND ACUPUNCTURE POINTS MAY HAVE EFFECTS ON PREGNANCY. PATIENTS MUST INFORM THE PRACTITIONER OF ANY POSSIBILITY OF PREGNANCY.

I will notify the Clinic Medical Staff member who is caring for me if I am or become pregnant.

I do not expect the Clinic Medical Staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the Clinic Medical Staff to exercise judgment during the course of treatment which the Licensed Acupuncturist thinks at the time, based upon the facts then known, is in my best interests.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

To be completed by patient or patient's representative if the patient is a minor or is physically or legally incapacitated.

To be completed by Licensed Acupuncturist providing information and obtaining consent.

Print Name of Patient

Print Name of Licensed Acupuncturist

Signature of Patient (or Representative)

Signature of Licensed Acupuncturist / Date Completed

Print Name of Representative

Print Name of Witness/Translator

Date Consent Completed _____

Signature of Witness/Translator

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Release of Information

All information provided herein is true and correct. I hereby consent to treatment. I give permission to my provider and staff to release information, verbal and written, contained in my medical record and other related information to related health care providers, assignees and/or beneficiaries and other related persons. I have read and understood this.

To be completed by patient or patient's representative if the patient is a minor or is physically or legally incapacitated.

Print Name of Patient

Print Name of Representative

Signature of Patient (or Representative)

Date _____

Payment Policy

Payment of all services rendered is due at the time of service to Blossoming Lotus Acupuncture. I have read and understood this policy

To be completed by patient or patient's representative if the patient is a minor or is physically or legally incapacitated.

Print Name of Patient

Print Name of Representative

Signature of Patient (or Representative)

Date _____

Appointment Cancellation Policy

I understand that 24 hours notice is required when canceling an appointment. I also understand that the full cost of the visit will be charged if I do not cancel 24 hours prior to the appointment.

Credit Card Information:

Name on Card: _____ VISA _____ MASTER CARD _____ DISCOVERY _____

Credit Card #: _____ EXP Date: _____ Verification code: _____

To be completed by patient or patient's representative if the patient is a minor or is physically or legally incapacitated.

Print Name of Patient

Print Name of Representative

Signature of Patient (or Representative)

Date _____