BLOSSOMING LOTUS ACPUNCTURE

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: ___________________________________

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:

General Symptoms
___ Poor appetite
___ Heavy appetite
___ Strongly like cold drinks
___ Strongly like hot drinks
___ Recent weight loss/gain
___ Poor sleep
___ Heavy sleep
___ Dream-disturbed sleep
___ Fatigue
___ Lack of strength
___ Bodily heaviness
___ Cold hand or feet
___ Fever
___ Chills
___ Night sweats
___ Sweat easily
___ Muscle cramps
___ Vertigo or dizziness

Head & neck
___ Headaches
___ Migraines
___ Concussions
___ Stiff neck
___ Swollen glands
___ Enlarged thyroid

Ears
___ Ringing
___ Hearing loss
___ Infections
___ Earache
___ Hearing Aids

Eyes
___ Glasses/contact lens (what age)
___ Blurred vision
___ Poor night vision
___ Floaters
___ Itchy eyes
___ Red eyes
___ Double vision
___ Cataract
___ Glaucoma

Nose, Throat & Mouth
___ Sinus infection
___ Nosebleed
___ Nasal congestion
___ Hay fever/allergies
___ Dry nose
___ Frequent sore throat
___ Lumps in throat
___ Difficulty swallowing
___ Mouth & tongue ulcers
___ Gum problems
___ Dry mouth
___ Thirst
___ Facial pain
___ TMJ
___ Loss of voice
___ Excessive phlegm

Respiratory
___ Difficulty breathing
___ Difficulty breathing when lying down
___ Wheezing
___ Asthma
___ Shortness of breath
___ Chest tightness
___ Wet cough
___ Dry cough
___ Coughing up phlegm
___ Coughing up blood
___ Pneumonia

Cardiovascular
___ High blood pressure
___ Low blood pressure
___ Chest pain
___ Palpitation
___ Rapid heartbeat
___ Irregular heartbeat
___ Blood clots
___ Fainting
___ Difficulty breathing
___ Swollen ankles
___ Phlebitis
___ Anemia
___ History of heart attack

Gastrointestinal
___ Nausea
___ Vomiting
___ Acid regurgitation
___ Gas
___ Hiccup
___ Bloating
___ Bad breath
___ Diarrhea
___ Constipation
___ Bloody stools (what color?)
___ Mucous in stool
___ Hemorrhoids
___ Itchy anus
___ Intestinal pain
___ Anal fissures
___ Laxative. What kind? How often?
___ Gall bladder disorder

Musculoskeletal
___ Neck/shoulder pain
___ Muscle pain
___ Upper back pain
___ Low back pain
___ Joint pain
___ Rib pain
___ Limited range of motion
___ Limited use
Other: ___________________________

Skin & Hair
___ Rashes
___ Hives
___ Ulcerations
___ Eczema
___ Psoriasis
___ Acne
___ Dandruff
___ Itching
___ Hair loss
___ Change in hair/skin texture
___ Fungal infections
Other: ___________________________

Neurological
___ Seizures
___ Tremors
___ Numbness or tingling
___ Poor memory
___ Anxiety
___ Depression
___ Poor coordination
___ Paralysis
Other: ___________________________

Genitourinary
___ Pain on urination
___ Frequent urination
___ Urgent urination
___ Blood in urine
___ Unable to hold urine
___ Incomplete urination
___ Bed wetting
___ Wake to urinate

___ Increased libido ___ Decrease libido ___ Kidney stone ___ Impotence ___ Premature ejaculation ___ Nocturnal emission	**Infection Screening** ___ HIV risks: self or partner ___ TB: self or household ___ Hepatitis risk: self or partner ___ History of sexually transmitted disease: self or partner	___ Gonorrhea ___ Chlamydia ___ Syphilis ___ Genital warts ___ 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: _____________________ Path 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:

____

Blossoming Lotus Acupuncture

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.

____

Print Name of Patient

____

Signature of Patient (or Representative)

____

Print Name of Representative

Date Consent Completed ____________________

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

____

Print Name of Licensed Acupuncturist

____

Signature of Licensed Acupuncturist / Date Completed

____

Print Name of Witness/Translator

____

Signature of Witness/Translator

Blossoming Lotus Acupuncture

Privacy Policy

Please sign and date to acknowledge that you have read and understand the below statements.

All patient information is confidential and private, Renee Chan L.Ac will not share or disclose any personal information for any reason without your consent.

____ ____

Print Name of Patient Print Name of Representative

____ Date ____

Signature of Patient (or Representative)

Should you wish Renee Chan, L.Ac to release your information or consult with other physicians regarding your treatment, please sign below.

____ ____

Signature of Patient (or Representative) Date

I permit Renee Chan, L.Ac to leave ____ phone and/or ____ text messages (please check) for me.

____ ____

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.

____ ____

Print Name of Patient Print Name of Representative

____ Date ____

Signature of Patient (or Representative)

Blossoming Lotus Acupuncture

Appointment Cancellation Policy

I understand that 48 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 48 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

____ Date ____

Signature of Patient (or Representative)