CONFIDENTIAL

The Lotus Acupuncture and Wellness Center 2717 N. 7th Street Phoenix, AZ 85006 Phone: (602) 396 5695

Welcome to The Lotus

Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. The Lotus Acupuncture and Wellness Center considers this information privileged physician/patient communication and will hold it in confidence.

Patient Information

Name: ________________________________ Today's Date: ______________

Address: ________________________________ City: ______________ State: ______

Zip: __________ Home phone: ______________ Work: ______________ Cell: ______________

Best number to reach you at: Hm. Wk. Cel. Email: ________________________________

Height ______ Weight ______ Age _____ Sex: c Male c Female Date of birth ______________

In emergency notify (name): ______________________ Emergency phone number: ______________________

Marital/Relationship Status: ______________________ Occupation: ______________________

Number of children: ________ Ages of children: ____________ Number who live with you: ________

Others living with you:____

Primary care doctor: ________________________________ Last seen: ______________________

Would you like to receive email regarding clinic discounts and special events? **c**Yes **c** No

How did you hear about us? ____

Current Health

Reason for your visit here today: ____

How long have you had this condition? ____

Rate the severity of the main complaint (1=mild, 10=severe) 1 2 3 4 5 6 7 8 9 10

Are you being treated for this condition by anyone else: **c** Yes **c** No

If Yes, who? ________________________________ Phone number: ______________________

Have these treatments helped? **c** Yes **c** Somewhat **c** Not much **c** Not at all

Has this condition been diagnosed by a MD? **c** Yes (Diagnosis: ______________________) c No

Women only: do you have any reason to believe that you are pregnant? Yes No

Known or suspected allergies: ____

Blood Pressure: What is your most recent blood pressure reading? ________

Past *Present* **EMOTION**

____ ____ Mood swings
____ ____ Mental tension
____ ____ Nervousness

ENERGY

____ ____ Fatigue
____ ____ Chronic infections
____ ____ Slow wound healing

NEUROLOGICAL

____ ____ Vertigo/dizziness
____ ____ Paralysis
____ ____ Numbness tingling
____ ____ Loss of balance
____ ____ Seizures/ epilepsy

ENDOCRINE

____ ____ Feeling hot or cold
____ ____ Hypothyroid
____ ____ Hypoglycemia
____ ____ Hyperthyroid
____ ____ Diabetes mellitus
____ ____ Night sweats

HEAD, EYE, EAR, NOSE, THROAT

____ ____ Impaired vision
____ ____ Glaucoma
____ ____ Tearing/ dryness
____ ____ Ear ringing
____ ____ Headaches
____ ____ Frequent sore throats
____ ____ Nose bleeds
____ ____ TMJ / jaw problems
____ ____ Eye pain/strain
____ ____ Glasses/contact
____ ____ Impaired hearing
____ ____ Earaches
____ ____ Sinus problems
____ ____ Hay fever
____ ____ Teeth grinding

RESPIRATORY

____ ____ Pneumonia
____ ____ Frequent common colds
____ ____ Persistent cough
____ ____ Difficulty breathing
____ ____ Shortness of breath
____ ____ Emphysema
____ ____ Pleurisy
____ ____ Asthma
____ ____ Tuberculosis

CARDIOVASCULAR

____ ____ Stroke
____ ____ Varicose veins
____ ____ Swelling of ankles
____ ____ Palpitations/ fluttering
____ ____ High blood pressure
____ ____ Heart disease
____ ____ Chest pain
____ ____ Heart murmurs
____ ____ Rheumatic fever
____ ____ Heart murmurs

GASTROINTESTINAL

____ ____ Ulcers
____ ____ Changes in appetite
____ ____ Nausea / vomiting
____ ____ Gallbladder disease
____ ____ Liver disease
____ ____ Hepatitis B or C
____ ____ Abdominal pain
____ ____ Undigested food in stool
____ ____ Blood in stool
____ ____ Epigastric pain
____ ____ Passing gas
____ ____ Belching
____ ____ Heartburn
____ ____ Hemorrhoids
____ ____ Diarrhea
____ ____ BM < once daily
____ ____ Mucous in stool

GENITO-URINARY TRACT

____ ____ Kidney disease
____ ____ Freq urinary tract infections
____ ____ Sexually transmitted disease
____ ____ Impaired urination
____ ____ Night-time urination
How many times?___
____ ____ Painful urination
____ ____ Frequent urination
____ ____ Kidney stones
____ ____ Blood in urine

MUSCULOSKELETAL

____ ____ Neck/ shoulder pain
____ ____ Muscle spasms/ cramps
____ ____ Mid back pain
____ ____ Low back pain
____ ____ Arm pain
____ ____ Upper back pain
____ ____ Leg pain
____ ____ Joint pain

MALE REPRODUCTIVE

____ ____ Sexual difficulties
____ ____ Testicular pain
____ ____ Prostate problems
____ ____ Penile discharge

FEMALE REPRODUCTIVE/BREAST

____ ____ Irregular cycles
____ ____ Breast lumps/ tenderness
____ ____ Bleeding between cycles
____ ____ Vaginal discharge
____ ____ Nipple discharge
____ ____ Menopausal
____ ____ Clotting
____ ____ PMS

Age period began: ______ How many days do you normally bleed? _______ Birth Control? _________

How heavy is the bleeding? Light Medium Heavy

What color is the blood? Light Red Red Dark Red Purple Brown Black

What is the consistency of the blood? Watery Thick Clots Dry Phlegmy

Do you suffer from painful periods? _________ When and how many days do you have pain? __________

Does your menstrual cycle follow a regular pattern? _____________

How many days from the start of one period to the start of another? __________

Date of last menstrual period: ___________________ Number of pregnancies: ______________

Number of abortions: ________________ Number of miscarriages: ______________

Do you currently have any infectious diseases? c Yes c No c Possibly

If Yes, please identify: HIV + c Hepatitis B c Hepatitis C c Flu / Cold c Streptococcus

c Mononucleosis c Tuberculosis c Other: ________________

Do you take Coumadin / Warfarin c Yes c No Do you take Plavix / Aspirin c Yes c No

Do you have a pacemaker c Yes c No

Childhood Illnesses (please check any that you have had):

____ Scarlet Fever ____ Diphtheria ____ Mumps
____ Rheumatic Fever ____ Measles ____ Chicken Pox

Do you smoke/chew tobacco? How much and how often?
Do you consume caffeine? How much and how often?
Do you consume alcohol? How much and how often?
Do you use recreational drugs? How much and how often?

How many glasses of water do you drink per day? ______ What other beverages do you consume daily? ____________

Interests and Hobbies: ____

Briefly describe your diet and any special diets:

____
____
____
____

PAIN

Please answer the following questions if you have pain. Indicate location of pain on diagram.

Quality of pain: __ Dull __ Sharp __ Stabbing
__ Sore __ Cramping __ Burning __ Fixed
__ Moves __ Constant __ Comes and goes
Rate on scale of 1 – 10 (10 = worst) _______

Does the pain radiate? Y / N
Where?________________________________

What reduces the pain? __ cold __heat __rest
__movement __pressure / massage __moisture
__nothing

What increases the pain? __cold __heat __rest
__movement __pressure / massage __moisture
__nothing

Please list all <u>prescription</u> and over the counter medications you are *currently* taking:

Drug Name	Reason for taking	For how long	Dose	Frequency

Please list all <u>supplements</u> and <u>herbs</u> you are *currently* taking:

Supplement	Reason for taking	Potency	Frequency

Past and Family Medical History

Please check all that apply:

	Self	Mother	Father	Sibling	Sibling	Partner	Child
Allergies							
Anemia							
Arthritis							
Autoimmune Disorder							
Cancer							
Depression							
Diabetes							
Heart Disease							
Hepatitis							
High Blood Pressure							
HIV / AIDS							
Hypo/Hyper Thyroid							
Kidney Stone							
Low Blood Pressure							
MRSA/Staff Infection							
Measles							
Mental Illness							
Multiple Sclerosis							
Stroke							
Tuberculosis							
Other							
Age At Death							

Hospitalizations, Surgeries, X-Rays, CAT scans, MRI's (please state the reason and when):

____

____

____

Please provide any information you wish to share that might not have been covered by the above questions :

____

____

The above information is true to the best of my knowledge.

X Signed: ______________________________ Today's Date: ______________

Parent / Guardian (if applicable) ______________________________

Appointment Cancellation Policy

Dear Patient;

We strive to render excellent alternative medical care to you and the rest of our patients. In attempt to be consistent with this, we have a strict appointment cancellation policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used for another patient.

Our Policy is as Follows:

We request that you give our office at least a 24-hour notice in the event that you need to reschedule your appointment. This allows other patients to be scheduled into that appointment time. It also makes it possible to reschedule your appointment more efficiently. Acceptable ways to cancel your appointment include cancellation via phone, voicemail, and/or email, cancellations via Facebook, Twitter, or 'word of mouth' are not acceptable. A **fee of $25.00** will be charged if you fail to provide 24-hour notice. If a patient accumulates a total of three (3) missed appointments, the patient will have to pre-pay for their next visit.

In the case of 'no call-no shows', where no notice is given and the appointment is missed. A **fee equal to 100% of the scheduled treatment** will be charged. If a coupon or gift certificate had intended to be used, said coupon will be marked as redeemed. This includes but is not limited to all Groupon, Living Social, and special promotion coupons.

If you have any questions regarding this policy, please let us know and we would be glad to clarify any question you may have.

We thank you for your patronage.

I have read and understand The Lotus Acupuncture and Wellness Center's Appointment Cancellation Policy and I agree to be bound by these terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I,____(print name), have received a copy of The Lotus Acupuncture and Wellness Center's Appointment Cancellation Policy.

____ ____

Printed Name of Patient Signature of Patient

____

Date