White Lotus Acupuncture

ACUPUNCTURE HEALTH HISTORY FORM

Name: _____ Date: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone:_____ Email Address: _____

May we email our monthly newsletter to your email address: ___yes ____no

Which phone number would you like us to call you? _____

May we call you at home?_____ Work?_____

Sex: _____ Date of Birth: _____ Height: _____ Weight: _____ Occupation: _____

Reason for today's visit: _____

Did your medical doctor diagnose the symptoms listed above? _____yes_____no

If so, what is the diagnosis: _____

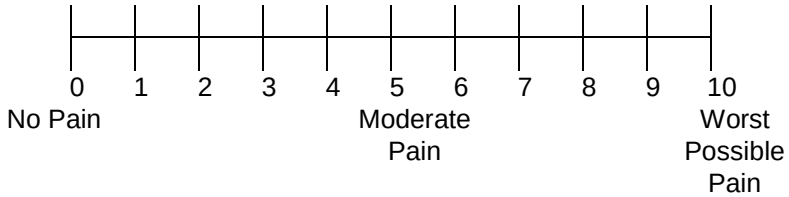
Have you seen your medical doctor in the last 6 months regarding this condition? ____yes _____no

Is your condition due to an accident or illness? _____

If referred, who referred you? _____

How would you rate your overall health today on a scale of 1 to 10? (1 = poor, 10 = excellent) _____

Are you in pain? __ Yes __ No If Yes, please rate your pain below:



List any present or prior surgeries, serious injuries, or illnesses you have had, and include dates:

What medications are you currently taking? Please include prescriptions, over-the-counter drugs, herbs, and vitamin supplements.

List physicians and health care providers whom you are currently consulting. List last dates seen and phone numbers if possible:

continues

Do you exercise? _____ What kind of exercise? _____

_____ How often? _____

Do you smoke? _____ If so, how often? _____

Do you drink alcohol? _____ If so, how often and how much? _____

Do you drink caffeinated products? _____ If so, how often and how much? _____

Please check if you have experienced the following within the last year:

___Allergy
___Areas of inflammation Where ____
___Arthritis Where _____
___Asthma
___High blood pressure ____/____
___Low blood pressure ____/____
___Bruise easily
___Bursitis Where _____
___Cancer or tumor Where _____
___Chest pain
___Diabetes
___Emphysema
___Heart condition Type _____
___Infectious condition Where _____
___Numbness/tingling Where _____
___Osteoporosis
___Sciatica
___Seizures/convulsions
___Shortness of breath
___Skin condition/rash Where _____
___Stroke
___Varicose veins

I hereby give my consent for physical assessment, treatment, and recommendations considered necessary by the practitioner designated by the White Lotus. I hereby authorize release of information from such procedures to my physician/complementary practitioners as indicated.

_____ _____
(signature) (date)

ACUPUNCTURE TREATMENT

Have you been treated with acupuncture before? _____ If so, for what condition?_____

For what reason(s) are you seeking acupuncture treatment?_____

_____

Please check if you have had any recent problems with any of the following:

HEAD:
___Headaches location _____
___Head feels heavy
___Loss of memory
___Lights bother eyes
___Loss of balance/dizziness/faintness
___Ringing in ears

ABDOMEN:
___Nausea
___Gas
___Constipation
___Diarrhea
___Tenderness

continues

continued

___Sinus
___Other _____

NECK:
___Pain with movement
___Stiff neck
___Grinding/popping sounds
___Decreased range of motion

JAW:
___TMJ
___Grind teeth
___Splint

SHOULDERS:
___Can't raise arm ___ Above shoulder ___ Over head
___Shooting pains

ARMS AND HANDS:
___Hands cold
___Loss of grip/strength
___Shooting pains

LOW BACK:
Pain is worse when:
___Lifting
___Sitting
___Lying down
___Bending
___Coughing/sneezing
___Working

HIPS, LEGS, AND FEET:
___Leg cramps
___Feet feel cold
___Ticklish
___Swollen ankles
___Shooting pains
___Hip replacement
___Knee surgery
___Pain
___Arch problems

FEMALES:
___Pregnant ____ # of weeks
___Menstrual pain
___Irregular cycle
___PMS symptoms _____

PLEASE CIRCLE ANY AREAS OF PAIN OR INJURY.

Other conditions or information:

_____

_____

Thank you for completing this form. I would like to remind you that at any time during the course of our work together, I cannot make any diagnosis. Any suggestions made during your visit are only recommendations.

I am aware that the information on this form has been requested to better provide therapeutic services and that it will be treated confidentially. I affirm that I have stated all known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I agree to give 24 hours notice when rescheduling or canceling an appointment. I understand that a $40 charge will be made when less then 24 hours notice is given and there is not an emergency. I further understand that acupuncture should not be construed as a substitute of medical examination, diagnosis, or treatment that is given by a physician, or other qualified medical specialist. By signing this release, I hereby waive and release the therapist and White Lotus Acupuncture & Holistic Services from all liability, past, present and future, relating to the acupuncture treatment.

Signature: _____ Date:_____

Parent/Guardian Signature (if patient is under 18): _____ Date: _____

Witness:_____Date:_____