NEW PATIENT HEALTH HISTORY FORM

Welcome to Lotus Healing, LLC! In order to provide you with the best care possible, it is important to have an understanding of how you are doing…physically, mentally, and emotionally. Please try to complete this form as thoroughly as possible. I am looking forward to working with you. Thank you!

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F Marital status: S M D W

Address:_____

Phone: Home:_____ Work:_____ Cell:_____

Email:_____ Best method to contact you:_____

1. Name of referring physician:_____

Address and phone number of physician:_____

_____

2. Reason for referral:_____

3. Please discuss the health concerns that have brought you to Lotus Healing, LLC. How do these concerns affect you?

_____

_____

_____

4. Have you ever tried acupuncture before? If yes, what were the results of your treatments?_____

_____

5. Please list any foods, drugs, or medications you are hypersensitive or allergic to:_____

_____

_____

5. Please list all medications (prescribed and over-the-counter) you are currently taking:_____

_____

_____

_____

6. Please list all supplements, vitamins, and herbs that you are currently taking:_____

_____

7. Do you have any reason to believe you may be pregnant? Yes No

If so, how far along are you? _____

7. Do you have any infectious diseases? Yes No If yes, please identify: _____

8. **Family History:** Check those applicable:	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Height:** _____ **Weight:** Currently: _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

11. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	

12. **X-Rays/CAT Scans/MRI's/Special Studies:**

Reason	When	Reason	When
_____		_____	
_____		_____	

13. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Anxiety Depression Panic Attacks Fear Other:_____

14. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome Other:_____

15. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems	Hay Fever
Migraines	Night Blindness	Other:_____		

16. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema
Persistent Cough	Pleurisy	Asthma	Tuberculosis
Shortness of Breath	Other: _____		

17. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease	Chest Pain	Swelling of Ankles	High Blood Pressure	Varicose Veins
Palpitations/Fluttering	Stroke	Heart Murmurs	Rheumatic Fever	Other:_____

18. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers	Changes in Appetite	Nausea	Vomiting	Epigastric Pain	Passing Gas
Heartburn	Belching	Gall Bladder Disease	Liver Disease	Hepatitis B or C	Hemorrhoids
Abdominal Pain	Other:_____				

19. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease	Painful Urination	Frequent UTI	Frequent Urination	Heavy Flow
Kidney Stones	Difficult Urination	Blood in Urine	Frequent Urination at Night	Other:_____

20. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles	Breast Lumps/Tenderness	Nipple Discharge	Heavy Flow
Vaginal Discharge	Premenstrual Problems	Clotting	Bleeding Between Cycles
Menopausal Symptoms	Difficulty Conceiving	Painful Periods	Other:_____

21. **Menstrual/Birthing History:**

1. Age of First Menses: _____	4. Birth Control Type: _____	7. # of Abortions: _____
2. # of Days of Menses: _____	5. # of Pregnancies: _____	8. # of Live Births: _____
3. Length of Cycle: _____	6. # of Miscarriages: _____	

22. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge Other:_____

23. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____ Other:_____

24. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy Other:_____

25. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Night Sweats Feeling Hot or Cold Other:_____

26. **Skin** (please circle any that you experience now and underline any that you have experienced in the past):

Rash Eczema Psoriasis Hives Itchy Acne Other:_____

27. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Cold Hands/Feet Sweat Easily Bleed or Bruise Easily Thirsty Poor Sleep

28. Is there anything else we should know? _____

_____

29. **Lifestyle:**

a. Do you typically eat at least three meals per day? Yes No If no, how many? _____

b. Exercise routine: _____

c. Stress coping practices: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Yes No

e. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Yes No Why/Why not? _____

f. Nicotine/Alcohol/Caffeine Use: _____

g. Have you experienced any major physical or emotional traumas? Yes No Please explain:_____

_____

h. How many glasses of water do you drink per day? _____

i. Interests and hobbies: _____

30. How did you hear about us?_____