

# Golden Lotus Healing Arts



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GoldenLotusHealingArts.com

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## New Patient Information

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Street Address \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Preferred Phone \_\_\_\_\_ Email \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Birth Time (if known) \_\_\_\_\_ Place of Birth \_\_\_\_\_

Age \_\_\_\_\_ Gender (F/M/T/Other) \_\_\_\_\_ Hobbies \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

### Referred by:

\_\_\_\_\_

### Emergency Contact:

Name \_\_\_\_\_ Phone \_\_\_\_\_

### Fees:

It is our policy that you pay the entire session fee or co-pay at the time of each session. We will provide a minimum of one month's notice of any changes to our fees.

Insurance Company \_\_\_\_\_

Insurance Company Phone Number (Provider Line) \_\_\_\_\_

ID # \_\_\_\_\_

Please bring a photocopy of your insurance card (front and back) **or** bring your card to your first appointment so we can make a copy at the clinic.

**Cancellation Policy:**

**If you need to change or cancel your appointment, please do so with a minimum of 24-hour notice. Failure to do so will result in being charged the equivalent of the cash rate of the missed appointment to your account.**

**I understand the cancellation policy.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_

**Health History**

Have you had acupuncture before? \_\_\_\_\_ If so, for what reason? \_\_\_\_\_

Main reason/s for seeking treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Any other complaints you would like to address? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Diagnosis from a medical professional (if applicable):

\_\_\_\_\_

Please list any major surgeries/hospitalizations and approximate dates:

\_\_\_\_\_

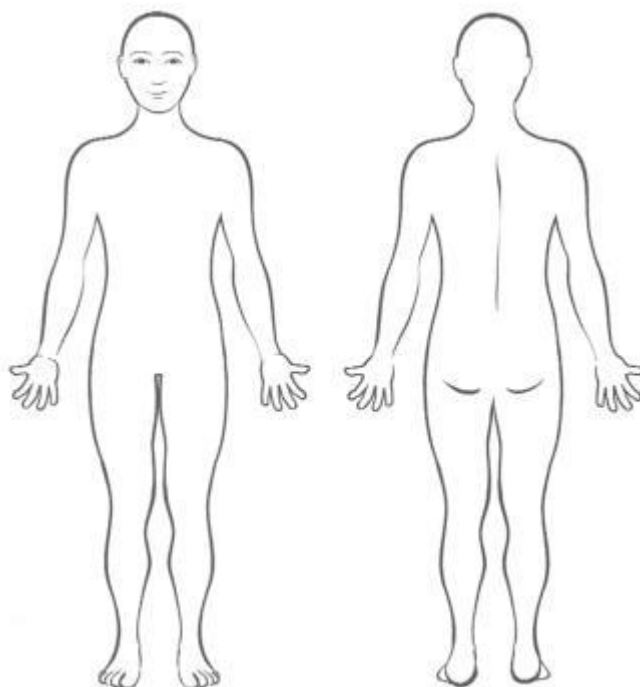
\_\_\_\_\_

Allergies (medications/foods/chemicals/etc.):

\_\_\_\_\_

\_\_\_\_\_

**Please mark any areas of pain or discomfort:**



**Please check any symptoms that you have experienced in the past or are currently experiencing:**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
sweating easily during the day	<input type="checkbox"/>	<input type="checkbox"/>	fatigue	<input type="checkbox"/>	<input type="checkbox"/>
night sweating	<input type="checkbox"/>	<input type="checkbox"/>	fevers	<input type="checkbox"/>	<input type="checkbox"/>
bleed or bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	chills	<input type="checkbox"/>	<input type="checkbox"/>
change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>
dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>	poor sleep	<input type="checkbox"/>	<input type="checkbox"/>

**Skin & Hair**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
rashes/hives	<input type="checkbox"/>	<input type="checkbox"/>	psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
eczema	<input type="checkbox"/>	<input type="checkbox"/>	loss of hair	<input type="checkbox"/>	<input type="checkbox"/>
acne	<input type="checkbox"/>	<input type="checkbox"/>	dryness	<input type="checkbox"/>	<input type="checkbox"/>

**Head, Ears, Eyes, Nose & Throat**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
earaches/pressure	<input type="checkbox"/>	<input type="checkbox"/>	headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>
ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	sinus pressure	<input type="checkbox"/>	<input type="checkbox"/>
hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
eye floaters	<input type="checkbox"/>	<input type="checkbox"/>	dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>
itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	teeth/jaw clenching	<input type="checkbox"/>	<input type="checkbox"/>
blurry vision	<input type="checkbox"/>	<input type="checkbox"/>			

### **Cardiovascular/Circulatory**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
chest pain	<input type="checkbox"/>	<input type="checkbox"/>	swelling/edema	<input type="checkbox"/>	<input type="checkbox"/>
fainting	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
cold hands & feet	<input type="checkbox"/>	<input type="checkbox"/>			

### **Respiratory**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
pain on inhaling	<input type="checkbox"/>	<input type="checkbox"/>	sneezing	<input type="checkbox"/>	<input type="checkbox"/>
chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	seasonal/other allergies	<input type="checkbox"/>	<input type="checkbox"/>
cough	<input type="checkbox"/>	<input type="checkbox"/>	phlegm production	<input type="checkbox"/>	<input type="checkbox"/>
asthma	<input type="checkbox"/>	<input type="checkbox"/>			

### **Genito-Urinary**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	urgent/frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	sores on genitals	<input type="checkbox"/>	<input type="checkbox"/>
pain upon urination	<input type="checkbox"/>	<input type="checkbox"/>	genital pain	<input type="checkbox"/>	<input type="checkbox"/>

### **Neurological/Psychological**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
anxiety	<input type="checkbox"/>	<input type="checkbox"/>	poor memory	<input type="checkbox"/>	<input type="checkbox"/>
depression	<input type="checkbox"/>	<input type="checkbox"/>	quick temper/impatient	<input type="checkbox"/>	<input type="checkbox"/>
sadness/ grief	<input type="checkbox"/>	<input type="checkbox"/>	worry/doubt	<input type="checkbox"/>	<input type="checkbox"/>
nervousness	<input type="checkbox"/>	<input type="checkbox"/>	fear/ overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>
loss of balance/coordination	<input type="checkbox"/>	<input type="checkbox"/>	sensitive/ stress easily	<input type="checkbox"/>	<input type="checkbox"/>
areas of numbness/paralysis	<input type="checkbox"/>	<input type="checkbox"/>	worry/ overthinking	<input type="checkbox"/>	<input type="checkbox"/>

### **Digestive**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
heartburn	<input type="checkbox"/>	<input type="checkbox"/>	gas	<input type="checkbox"/>	<input type="checkbox"/>
belching	<input type="checkbox"/>	<input type="checkbox"/>	diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
bloating	<input type="checkbox"/>	<input type="checkbox"/>	constipation	<input type="checkbox"/>	<input type="checkbox"/>
nausea	<input type="checkbox"/>	<input type="checkbox"/>	abdominal pain/cramps	<input type="checkbox"/>	<input type="checkbox"/>

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
vomiting	<input type="checkbox"/>	<input type="checkbox"/>	mucus in stool	<input type="checkbox"/>	<input type="checkbox"/>
chronic bad breath	<input type="checkbox"/>	<input type="checkbox"/>	blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
sores on lips/tongue	<input type="checkbox"/>	<input type="checkbox"/>	hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>

**For Female Body**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	breast pain	<input type="checkbox"/>	<input type="checkbox"/>
painful periods	<input type="checkbox"/>	<input type="checkbox"/>	vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>
bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>	vaginal sores	<input type="checkbox"/>	<input type="checkbox"/>
period clots	<input type="checkbox"/>	<input type="checkbox"/>	hot flashes/ temp issues	<input type="checkbox"/>	<input type="checkbox"/>
menstrual cramping	<input type="checkbox"/>	<input type="checkbox"/>	night sweating	<input type="checkbox"/>	<input type="checkbox"/>

age of first menses \_\_\_\_\_ duration of typical period \_\_\_\_\_

duration of typical cycle \_\_\_\_\_ date of last PAP \_\_\_\_\_

# of pregnancies \_\_\_\_\_ # of live births (+ years) \_\_\_\_\_

# of miscarriages \_\_\_\_\_ # of abortions \_\_\_\_\_

Have you been through menopause? Age? \_\_\_\_\_

Have you ever taken birth control? \_\_\_\_\_ Oral or Other? \_\_\_\_\_

When and for how long? \_\_\_\_\_

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

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**For Male Body**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
erectile dysfunction/impotence	<input type="checkbox"/>	<input type="checkbox"/>	ejaculatory pain	<input type="checkbox"/>	<input type="checkbox"/>
varicocele	<input type="checkbox"/>	<input type="checkbox"/>	BPH	<input type="checkbox"/>	<input type="checkbox"/>
urinary issues/ pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate issues/ pain	<input type="checkbox"/>	<input type="checkbox"/>
pelvic pain/ discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Tension/ Body pain	<input type="checkbox"/>	<input type="checkbox"/>

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**Lifestyle**

Current medications/herbs/supplements:

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Do you follow any certain diet or way of eating? (vegan, vegetarian, gluten-free, paleo, etc.)

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Current exercise routine:

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Do you use tobacco? If so, how often? Do you drink alcohol? If so, how many drinks/week?

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Are you currently taking any of the following medications?

*(circle if yes and indicate how often)*

Advil/Motrin/Ibuprofen

Aleve/Naproxen

Bayer/Aspirin

Celebrex/Celecoxib

Prednisone/Prednisolone

Lisinopril/Atenolol

Have you ever had a seizure? If yes, indicate date of last: \_\_\_\_\_

**Please circle any significant illnesses and indicate date:**

Cancer

Hepatitis

Diabetes

High blood pressure

Epilepsy

Heart Attack

Stroke

Ulcer Disease

Liver Disease

Colon Polyps

Other \_\_\_\_\_

**Family Medical History**

Cancer    Seizures    High blood pressure    Stroke    Diabetes

Heart Attack    Hepatitis    Asthma    Other \_\_\_\_\_

**Please list any other relevant information or issues you would like to discuss:**

*Welcome to Golden Lotus Healing Arts! Thank you for taking the time to fill out these forms. I look forward to working with you and supporting you on your journey. Please let me know if you have any questions or concerns!*