LOTUS PROFESSIONAL COLLEGE

Please Print Clearly

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.	*Legal Last Name*	*First Name*	*Middle In.*
Age	*Date of Birth*	*Place of Birth*	*Social Security No.*

Marital Status ❑ Single ❑ Married ❑ Cohabitating ❑ Separated ❑ Divorced *Sex* ❑ Female ❑ Male

Home Address			*PO Box /Billing Address*		
City	*State*	*Zip Code*	*City*	*State*	*Zip Code*
Home Phone	*Mobile Phone*	*Work Phone*	*Email Address*		
Occupation			*Employer*		*How long?*

EMERGENCY CONTACT & RELEASE OF INFORMATION

Persons to whom confidential information may be released.

Full Name	*Relationship*
Address	*Phone*
Full Name	*Relationship*
Address	*Phone*

REFERRAL - WERE YOU REFERRED BY A PHYSICIAN?

❑ Yes *Physician Name* *Phone*

❑ No Have you received a diagnostic exam or treatment in the last six months from a licensed doctor of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment? ❑ Yes ❑ No

Primary Care Provider *Phone*

How did you hear about us? ❑ Advertisement ❑ Web-site ❑ *Family/Friend*

❑ *Other*

PATIENT TERMS OF SERVICE AGREEMENT

_____ I certify that all the information I provided on this form is true and accurate to the best of my knowledge.

_____ I agree to adhere to all policies as well as any future alterations or changes to the Office Policies.

_____ I agree to provide Lotus Professional College 24 hours' notice when canceling a scheduled appointment.

_____ I understand that if I cancel an appointment without providing the required notice, I will be charged a cancelation fee.

Signature *Date*

Print Name

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Patient Name: _____ **Date:** _____

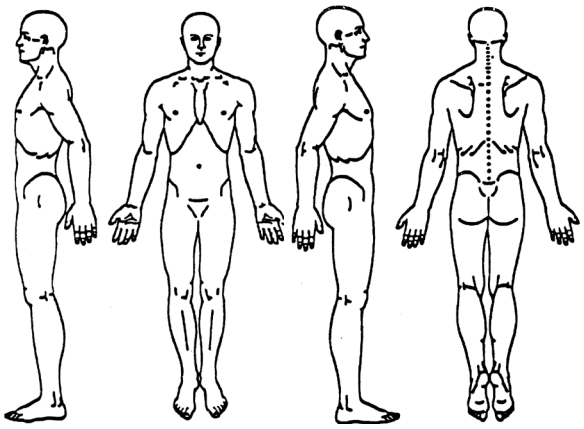
Marital Status ❑ Single ❑ Married ❑ Cohabitating ❑ Separated ❑ Divorced **Children?** _____

❑ **F** ❑ **M** *Age* _____ *Height* _____ *Dressed weight* _____ *How long this weight?* _____

What is your primary reason for this visit? (including: when & where it began, severity, frequency of symptoms)

What diagnosis/explanations have you received? (if any)

Please mark areas most affected this condition.



How does this condition affect your daily life?
Triggers? Makes worse? Makes better?

What types of treatment have received/tried and how effective were they? Treatment • Date(s) • Practitioner • Effect

Physician & Health Care Providers - Please list your primary care provider & any others you are currently being treated by.

Provider Name	Specialty – Treatment	Phone

Please list any other major health problems you would like treatment for.

Have you ever been treated with Traditional Chinese Medicine, acupuncture or Chinese herbs? ❑ NO ❑ YES

(If yes: When, Where, Result?)

How would you rate your overall health?	*Very poor*	1	2	3	4	5	6	7	8	9	10	*Excellent*
How would you rate your energy level?	*Very poor*	1	2	3	4	5	6	7	8	9	10	*Excellent*

At what point in your life did you feel the best?

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Check any illnesses or conditions you have or had in the past

- ❑ Allergies
- ❑ Antibiotic uses
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Injury
- ❑ Bleeding tendencies
- ❑ Broken Bones or Fractures
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chicken pox
- ❑ Chronic Fatigue
- ❑ Crohn's Disease Ulcerative Colitis
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy convulsions/seizures
- ❑ Gall Stones
- ❑ Glaucoma
- ❑ Gonorrhea
- ❑ Gout
- ❑ Head injury
- ❑ Heart Attack, Angina
- ❑ Heart Failure
- ❑ Heart trouble, other
- ❑ Hepatitis
- ❑ Herpes
- ❑ High blood fats cholesterol, triglycerides
- ❑ High blood pressure
- ❑ HIV – AIDS
- ❑ Irritable bowel chronic diarrhea
- ❑ Jaundice
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Meningitis
- ❑ Mental Illness
- ❑ Mononucleosis
- ❑ Multiple sclerosis
- ❑ Mumps or Measles
- ❑ Neck injury
- ❑ Nervous disorder
- ❑ Parasites
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic fever
- ❑ Sinusitis
- ❑ Seizures
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Syphilis
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Vein trouble
- ❑ Whooping Cough
- ❑ Other _____
- ❑ Other _____
- ❑ Other _____
- ❑ Other _____

Immunizations

❑ Smallpox ❑ Tetanus ❑ Diphtheria ❑ Pertussis ❑ Polio ❑ Mumps ❑ Measles
❑ Rubella ❑ Cholera ❑ Typhoid ❑ Influenza ❑ Other _____

Men only - ***List any hormone regulating medications you take (such as Propecia®):***

- ❑ Family history of prostate cancer
- ❑ Diagnosed with prostate cancer
- ❑ Prostate infection
- ❑ Premature ejaculation
- ❑ Erectile dysfunction
- ❑ Male Infertility
- ❑ Pain or swelling of testicles
- ❑ Trauma to testicles
- ❑ Other:

Hospitalizations or surgeries: in & out-patient services *Attach list at end if necessary

Date	Description	Outcome

List all medications (prescription & over-the-counter) you are currently taking. *Attach list at end if necessary

Medication	Dosage	Date Started	Date Stopped
Cortisone type drugs? ❑ NO ❑ YES			

Recent Lab Tests	Date	Result

Sleep

Time to sleep:	Time to rise:	Hours:	Do you have trouble falling asleep? ❑NO ❑YES
Do you wake up in the night? ❑ NO ❑ YES		Why? What time?	
Are you rested in the morning? ❑ NO ❑ YES		*Other comments:*	

How good do you feel your nutrition is?

Do you follow a special Diet?

❒ Diabetic ❒ Low carb ❒ Ovo-lacto ❒ Vegetarian ❒ Blood type diet
❒ Dairy restricted ❒ Gluten Free ❒ Paleo ❒ Vegan ❒ Other

Usual Breakfast		Usual Lunch		Usual Dinner	
❑ None	❑ Sweet roll	❑ None	❑ Pizza	❑ None	❑ Poultry
❑ Bacon/Sausage	❑ Sweetener	❑ Butter	❑ Potato chips	❑ Beans (legumes)	❑ Red meat
❑ Bagel	❑ Tea	❑ Coffee	❑ Salad	❑ Brown rice	❑ Rice
❑ Butter	❑ Toast	❑ Eat in cafeteria	❑ Salad dressing	❑ Butter	❑ Salad
❑ Cereal	❑ Water	❑ Eat in restaurant	❑ Soda	❑ Carrots	❑ Salad dressing
❑ Coffee	❑ Wheat bran	❑ Fish sandwich	❑ Soup	❑ Coffee	❑ Soda
❑ Donut	❑ Yogurt	❑ Fried foods	❑ Sugar	❑ Fish	❑ Sugar
❑ Eggs	❑ Oatmeal	❑ Hamburger	❑ Sweetener	❑ Green vegetables	❑ Sweetener
❑ Fruit	❑ Milk protein shake	❑ Hot dogs	❑ Tea	❑ Juice	❑ Tea
❑ Juice	❑ Slim fast	❑ Juice	❑ Tomato	❑ Margarine	❑ Vinegar
❑ Margarine	❑ Carnation shake	❑ Leftovers	❑ Vegetables	❑ Milk	❑ Water
❑ Milk	❑ Soy protein	❑ Lettuce	❑ Water	❑ Pasta	❑ White rice
❑ Oat bran	❑ Whey protein	❑ Margarine	❑ Yogurt	❑ Potato	❑ Yellow vegetables
❑ Sugar	❑ Rice protein	❑ Mayo	❑ Slim fast	❑ Other:	
❑ Other		❑ Meat sandwich	❑ Carnation shake		
		❑ Milk	❑ Protein shake		
		❑ Other			

Water intake per day?

Typical snacks?

Worst foods in your diet?

What foods do you crave? *Sweet / salty / etc.*

Alcohol	x week	Coffee	x week	Artificial Sweeteners	x week
Soda	x week	Smoking	x week	Recreational Drugs	x week

Dietary Supplements	Dosage	Purpose	Length of use

Type of Exercises You Do	Times per week

Elimination

Bowel Consistency ❑ Hard ❑ Loose ❑ Well-formed ❑ Float ❑ Sink ❑ Blood ❑ Mucus ❑ Undigested food

Do bowel movements feel complete? ❑ YES ❑ NO Painful bowel movements? ❑ YES ❑ NO

Urination ❒ Frequent Infections ❒ Burning ❒ Urgent ❒ Retention ❒ Scanty ❒ Profuse ❒ Dribbling ❒ At Night

Sexuality

❑ YES ❑ NO	Are you sexually active?
❑ YES ❑ NO	Do you feel satisfied by your sexual experiences?
❑ YES ❑ NO	Difficulty experiencing orgasm
❑ YES ❑ NO	Have you had more than one sex partner in the past 6 months?

How would you describe your health and emotional state as a child?

Stress & Emotions

Current level of stress you experience? *Very Low* 1 2 3 4 5 6 7 8 9 10 *High*

Major causes of stress (e.g. changes in job, home life, finances):

Any recent major life changes?

What is your opinion of yourself?

How do you feel about your home environment?

How do you feel about your work environment?

Activities that give you a sense of pleasure & accomplishment?

What is the most negative emotion you experience? When & where?

In order to improve your health, how willing are you to…

	Not Willing				*Very Willing*
Significantly modify your diet	1	2	3	4	5
Take nutritional supplements each day	1	2	3	4	5
Keep a record of everything you eat each day	1	2	3	4	5
Modify your lifestyle (e.g. work demands, sleep habits)	1	2	3	4	5
Practice relaxation techniques	1	2	3	4	5
Engage in regular exercise	1	2	3	4	5
Have periodic lab tests to assess progress	1	2	3	4	5

I certify that I have answered all questions honestly, to the best of my ability and that the information I have provided is accurate.

Signature *Date*

Women Only

Maternal Family History

❑ Infertility ❑ PMS ❑ Fibroids ❑ Endometriosis ❑ Menopause ❑ Cancer:

❑ Other: | Medications your mother took while pregnant with you (if any):

Medical Exam/Test	Date	Physician	Result
Pelvic Exam			
Pap Smear			
Mammography			
Other:			

Menstrual Cycle

Age of first period	*Date of last cycle*	*Average number of days from start of one period to start of next:*	
❑ YES ❑ NO *Are your menstrual cycles regular?*		*Average number of days of flow:*	
Flow is ❑Light ❑Normal ❑Heavy	*Color is* ❑Pale ❑Normal ❑Dark ❑Bright Red ❑Brown	*Blood Clots* ❑YES ❑NO	

Do you experience pain or cramping? ❑ Before ❑ During ❑ After ❑ None
Do you get nausea or vomiting with your period? ❑ Before ❑ During ❑ After ❑ None
Does your energy level change? ❑ Before ❑ During ❑ After ❑ None

Do you experience any of the following before your period each month?

❑ Water retention ❑ Food cravings ❑ Breast tenderness or swelling
❑ Mental depression ❑ Migraines ❑ Vaginal discharge between periods
❑ Irritability ❑ Dizziness ❑ Bleed or spot between periods
❑ Loose Stools ❑ Other:

Contraception Use: Type	Dates of Use / How Long	Any Reactions / Side Effects

Pregnancies: Description / Complications	Delivery, Miscarriage, or Termination	Dates
	❑ Delivery ❑ Miscarriage ❑ Termination	
	❑ Delivery ❑ Miscarriage ❑ Termination	
	❑ Delivery ❑ Miscarriage ❑ Termination	
	❑ Delivery ❑ Miscarriage ❑ Termination	

Mark all that apply

❑ Sexually transmitted disease ❑ Sores on your genitals ❑ Yeast infections
❑ Uterine fibroids or polyps ❑ Endometriosis ❑ Varicose veins
❑ Sore heels when walking ❑ Incompetent Cervix ❑ Painful intercourse
❑ Numb legs/feet when standing still ❑ Pelvic inflammatory disease ❑ Diagnosed with pelvic adhesions
❑ Cervical Biopsy ❑ Cervical Cauterization ❑ Cervical Conization
❑ Diagnosed with any pelvic abnormalities:

Have you experienced Menopause ❑ NO ❑ YES, Age:

Describe any menopausal symptoms

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BODY SYSTEM REVIEW

Please circle what applies to you

1 - Never	2 - Rarely	3 - Occasionally	4 - Frequently	5 - Always

1	2	3	4	5	low appetite	1	2	3	4	5	ravenous appetite
1	2	3	4	5	loose stools	1	2	3	4	5	heartburn/acid reflux
1	2	3	4	5	mouth sores	1	2	3	4	5	fatigue after eating
1	2	3	4	5	gas/bloating after food	1	2	3	4	5	bruise easily
1	2	3	4	5	bleeding/swollen gums	1	2	3	4	5	thirst
1	2	3	4	5	organ prolapsed (diagnosed)	1	2	3	4	5	belching or vomiting
1	2	3	4	5	allergies	1	2	3	4	5	catch colds easily
1	2	3	4	5	asthma	1	2	3	4	5	shortness of breath
1	2	3	4	5	general weakness	1	2	3	4	5	cough
1	2	3	4	5	dry nose/mouth/skin/throat	1	2	3	4	5	nasal discharge
1	2	3	4	5	feel worse after exercise	1	2	3	4	5	sinus congestion
1	2	3	4	5	sore, cold or weak knees	1	2	3	4	5	feel cold, in core
1	2	3	4	5	low back pain	1	2	3	4	5	cold hands &/or feet
1	2	3	4	5	frequent urination	1	2	3	4	5	urinary incontinence
1	2	3	4	5	early morning diarrhea	1	2	3	4	5	hearing loss
1	2	3	4	5	impaired memory	1	2	3	4	5	edema
Normal		*High*		*Low*	libido / sex drive			❑ YES	❑ NO		hair loss
1	2	3	4	5	muscle spasms/twitches	1	2	3	4	5	irritable
1	2	3	4	5	feel better after exercise	1	2	3	4	5	numb extremities
1	2	3	4	5	tightness in chest	1	2	3	4	5	dry eyes
1	2	3	4	5	alternating diarrhea & constipation	1	2	3	4	5	ear ringing
1	2	3	4	5	symptoms worse with stress	1	2	3	4	5	anger easily
1	2	3	4	5	neck/shoulder tension	1	2	3	4	5	red eyes
1	2	3	4	5	feel heart beating	1	2	3	4	5	chest pain
1	2	3	4	5	insomnia	1	2	3	4	5	disturbing dreams
1	2	3	4	5	sores on tip of tongue	1	2	3	4	5	headaches
1	2	3	4	5	chest pain traveling to shoulders	1	2	3	4	5	restlessness
Normal		*High*		*Low*	overall body temperature	1	2	3	4	5	anxiety
Normal		*High*		*Low*	overall energy level	1	2	3	4	5	panic attacks
1	2	3	4	5	see floaters in eyes	1	2	3	4	5	foggy thinking
1	2	3	4	5	heat in palms or soles	1	2	3	4	5	dizzy upon standing
1	2	3	4	5	feeling of heaviness	1	2	3	4	5	nausea
1	2	3	4	5	afternoon fever	1	2	3	4	5	night sweats
1	2	3	4	5	enlarged lymph nodes	1	2	3	4	5	cloudy urine
1	2	3	4	5	face flushes						

Family Health History Mark all that apply	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Children**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**
Age - if still living									
Age at death									
Heart Attack / Disease									
Stroke									
Breast Cancer									
Colon Cancer									
Prostate Cancer									
Skin Cancer									
Uterine or Ovarian Cancer									
Cancer, Other									
ADD/ADHD									
ALS: other Motor Neuron Diseases									
Alzheimer's / Dementia									
Blood disorders: Anemia/clotting problems									
Anxiety / Depression									
Arthritis: Rheumatoid / Psoriatic									
Osteoarthritis									
Asthma / Emphysema									
Autism									
Autoimmune Diseases									
Bladder / Kidney disease									
Celiac disease									
Obesity - Diabetes									
Eczema / Psoriasis									
Environmental Sensitivities									
Epilepsy									
Glaucoma									
High Blood Pressure									
High Cholesterol									
Sleep Apnea/ Insomnia/ Other									
Irritable Bowel Syndrome									
Multiple Sclerosis									
Osteoporosis									
Parkinson's									
Psychiatric: Bipolar, Schizophrenia, Etc.									

Family Health History Mark all that apply	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Children**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**
Smoking addiction									
Substance abuse									
Ulcers									

Recommendation for Examination by a Physician

I, _____, recommend to you
(Acupuncture student)

_____ that you be examined by a
(patient)

physician regarding the condition for which you are seeking acupuncture treatment.

I understand this recommendation.

_____ _____
Patient Date

Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment. (*Code of Virginia* §54.1-2956.9, 18 VAC 85-110-10).

_____ _____
Acupuncture Student Date

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ACUPUNCTURE INFORMED CONSENT TO TREAT FROM ACUPUNCTURE STUDENT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncture student indicated below and/or other licensed acupuncturists who now or in the future treat me while a student, employed by, working or associated with, or serving as back-up for the school named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical student or staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical student to exercise judgment during the course of treatment which the clinical student thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above 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 agree with the current or future recommendations for care. 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.

Patient Name: _____

Student's Name: _____

Patient Signature: _____ Date: _____