Lotus Blossom Clinic - Patient Intake Form *(do not remove from clinic without written authorization)*

How did you find out about us? _____

Name: _____ **Birth Date** ____/____/_____ **Marital Status** _____**Gender**_____

Phone: _____ (home) _____ (cell) **Emergency contact** _____ **Phone**_____

Address_____ City _____State _____Zip_____

Email Address _____**Referred by:** _____

Reason for visit today _____

Physician's contact information: _____

Family Medical History ___Diabetes ___ Cancer ___ High Blood Pressure ___Heart Disease ___Stroke ___Asthma ___Allergies ___Alcoholism ___Other _____

Your past medical history: _____ **Pacemaker or other electronic device?** _____ **Allergic to nuts?**

Significant illness? _____

Surgeries? _____

List the drugs and supplements you are taking: _____

_____

_____

_____

Habits/Diet ____Cigarettes ____Coffee ____Tea ____ Cola ____Alcohol ____Drugs ____Sugar ____Salt

_____Exercise _____ **Other?** _____

General Please check if any currently apply

☐ Fevers ☐ Cravings ☐ Sweat Easily ☐ Tremors ☐ Night Sweats ☐ Fatigue ☐ Cancer	☐ Chills ☐ Localized Weakness ☐ Change in appetite ☐ Poor coordination ☐ Thyroid Disease ☐ Allergies ☐ Rheumatic Fever	Sudden Energy Drop - Time of day _____ ☐ Do You Get Cold? Where? _____ ☐ Is your Appetite? Poor Average Heavy ☐ Is your Sleep? Poor Average Heavy ☐ Do you have any Peculiar Tastes or Smells? ☐ Do You Bleed Easily? Where?_____ ☐ Anything Else _____

Skin and hair

☐ Rash ☐ Itching	☐ Ulcerations ☐ Pimples	☐ Hives ☐ Dandruff	☐ Purpura ☐ Hair loss	☐ Pain ☐ Other?_____

Head, Eyes, Ears, Nose, and Throat

☐ Headache/Migraine ☐ Pain in head or face ☐ Jaw Pain/Click	☐ Eye Pain ☐ Poor Vision ☐ Ear Pain	☐ Ringing in ear ☐ Poor hearing ☐ Sinus	☐ Nose pain ☐ Congestion ☐ Sore throat	☐ Problem swallowing ☐ Mouth/Gums/Teeth ☐ Other? _____

Cardiovascular

☐ Blood Clots ☐ Fainting ☐ Dizziness	☐ Phlebitis ☐ Chest Pain ☐ Difficult Breathing	☐ Heart? _____ ☐ Swollen hands/feet ☐ Cold hands/feet	☐ High Blood Pressure ☐ Low Blood Pressure ☐ Other? _____

Fill out both sides

Respiratory

☐ Cough ☐ Pneumonia	☐ Asthma ☐ Bronchitis	☐ Tight Chest ☐ Phlegm (Color?)	☐ Easily out of Breath ☐ Other? _____

Gastrointestinal

☐ Nausea ☐ Gas ☐ Bad Breath ☐ Constipation ☐ Pain or Cramps	☐ Vomiting ☐ Belching ☐ Rectal Pain ☐ Bloody/Black Stools ☐ Laxative use _____	☐ Diarrhea ☐ Hemorrhoids ☐ Sensitive Abdomen	Bowel Movements Frequency_____ Color_____ Odor_____ Texture_____ Other? _____

Genito-Urinary

☐ Painful Urination ☐ Incontinence	☐ Kidney Stones ☐ Blood in Urine	☐ Hemorrhoids ☐ Venereal Disease	☐ Libido (High) (Low) ☐ Other? _____

Pregnancy and Gynecology

☐ Number of pregnancies ☐ Age at first menses ☐ Flow (Describe)_____ _____ ☐ Vaginal discharge	☐ Number of births ☐ Period (days) ☐ Clots ☐ Vaginal sores	☐ Breast Lumps or tenderness ☐ Painful periods Last Pap _____ ☐ Changes in body/psyche prior to menstruation ☐ Birth Control (Type and duration)_____	☐ Premature births ☐ Miscarriages ☐ Irregular periods ☐ Last menses _____ ☐ Menopause _____

Musculoskeletal

☐ Neck Pain ☐ Joint or bone problems	☐ Muscle pain	☐ Back Pain (where)	☐ Joint pain (where) _____ _____

Neuropsychological

☐ Treated for emotional problems ☐ Depression ☐ Anxiety	☐ Areas of numbness ☐ Restless Legs Syndrome ☐ Poor Memory	☐ Bad temper ☐ Seizures	☐ Concussion ☐ Easily stressed
☐ Other Neurological or Psychological problems?			

Comments_____

_____

_____

_____

_____

_____

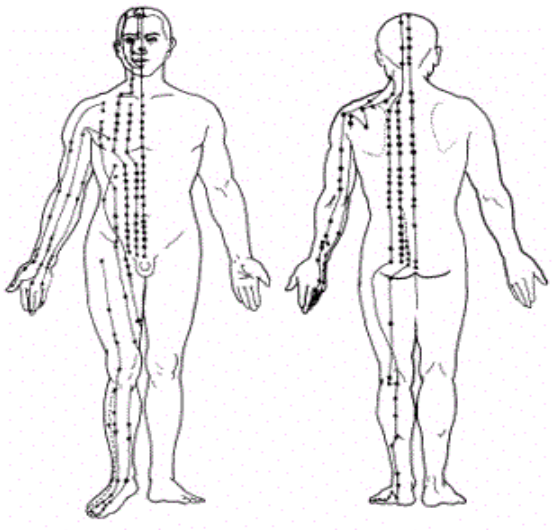
_____

_____

_____

_____

Mark your area of concern



Research has shown that you are what you eat. As a Holistic Health Clinic it's imperative for us to know what you are eating so that we can properly assist you in creating your highest –level of health. So, PLEASE BE HONEST and share with us your last four typical Breakfasts, lunches, dinners and snacks in the spaces provided.

BREAKFAST	LUNCH	DINNER	SNACK

Patient Name: _____ Date: _____

INFORMED CONSENT TO TREAT

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 acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist 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, hypnosis, facials, life coaching, meditation, educational tools 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 be 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 have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including 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 spontaneous miscarriage, 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

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.

By voluntarily signing below, I show 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 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.
(Date)

X (Date)

(PATIENT SIGNATURE Or Patient Representative) (Indicate relationship if signing for patient)

Lotus Blossom Clinic Financial and Appointment Policy

As of 7/17/2019

Full payment is due at time of service. Our fees are determined by the complexity of the visit; self-pay rates are as follows:

The fee to see our **Acupuncture Physicians** for acupuncture, oriental medicine consultation, or functional medicine is:

$95, for your first visit ($70 for children up to 16 years old), and

$75 for subsequent visits ($50 for children up to 16 years old).

- **Massage Therapists**: $80/hour
- **Medicinal Food Consultation**: $55
- **Reiki/Energy Healing** is $55/hour, package of 2 for $100 or package of 4 for $180
- **Private Sound Healing Sessions** are $55/hour
-

For homeopathic medicine the initial visit is $95 and subsequent visits are $50.

Self-pay prices are subject to change from time to time.

Missed appointments: **Unless canceled at least 24 hours in advance, our policy is to charge A $30 fee for missed for appointments.** Your treatment schedule will be carefully planned. Adhering to the plan is important for your progress. By signing this policy you also understand that it is our policy to, on occasion, confirm appointments by calling the phone number(s) listed on your intake form and we may, from time to time, leave a voice message.

This clinic does not submit all insurance claims. We will be happy to print a ledger at your request for you to submit to your insurance.

Declaration: I have read, understand and agree to this financial and appointment policy.

A photocopy of this instrument shall be just as effective as the original for all purposes.

Signature of Patient

and/or Responsible Party: _____

If interested in our other services, please check blue box.

Check Areas of Interest (Blue)			Comments/Recommendations
	Acupuncture		
	Massage Chinese Medical Massage Cranial Sacral Myofascial Release Swedish & Thai Deep Tissue Polarity Therapy		
	Live Blood Analysis		
	Food Healing Integrative Nutritional Coaching		
	Reiki (Energy Healing)		
	Sound Healing Crystal & Tibetan Bowls		
	Natural Facials		
	Herbs/Supplements		