LOTUS ENERGY
ACUPUNCTURE CLINIC

ACUPUNCTURE ASSESSMENT:

Personal Info

Name_____ Date_____

Home phone_____ Cell_____ Work_____

Address_____

Date of Birth_____ Height_____ Weight_____

Occupation_____ Marital Status_____

Email_____ Employer_____

InsuranceCo._____

Emergency Contact_____

Your Main Health Concern (please describe your experience)_____

_____

_____

Do you have a diagnosis by an M.D./Specialist? Do you have lab/scan/test results?

_____

What other forms of treatment have you experienced?_____

_____

Is this your first time having a **Traditional Chinese Medicine Acupuncture** treatment?_____

Please list all accidents/ injuries/surgeries with dates_____

_____

Family Medical History: _____

_____

Do you have **allergies/ food sensitivities**?_____

_____

List all **medications,vitamins,herbs, homeopathics**_____

_____

_____ How many alcoholic beverages per week?_____ Do you smoke cigarettes?_____ Any drugs?_____

Please check if you experience pain in the following:

__neck __leg/calf cramps __poor posture __low back pain __muscle weakness
__sciatica __swollen joints __shoulders __bursitis __rheumatoid arthritis
__muscle spasms __wrists/fingers __chest/ribs __numbness in toes/fingers __knees
__herniated disc __scoliosis __feet __hips __sciatic __headaches
__degenerative disc __tailbone __tendinitis __ears __thighs/groin __calves

Please check if you are experiencing any of these symptoms:

__lack of appetite __excessive appetite __loose stools __diarrhea __constipation __vomiting __difficult digestion __abdominal pain __hemorrhoids __colitis __diverticulitis __belching __hiccups __heartburn/acid reflux __recent antibiotics __insomnia __heart palpitations __nightmares __mentally restless __angina __chest tightness __anxiety __poor memory __dry eyes __dry skin __dry hair __dry mouth __mouth/gum sores __hearing loss __tinnitus (ringing-high or low) __hair loss __urinary pain __frequent urination __kidney stones __low libido __coldness in ankles, knees __cough __shortness of breath __decreased sense of smell __hay fever __asthma __skin eruptions __rhinitis __sinus infection __post nasal drip __bronchitis __eye problems __jaundice __gall stones __light coloured stools __soft/brittle nails __easily angered __difficulty in making decisions __dizziness __spasms/twitching muscles __PMS __depression/anxiety __sighing __pain/discomfort in lower ribs __fatigue __ edema __easily bruised __blood in stool __black tarry stool __difficult to stop bleeding __dizziness __nosebleeds __tendency to faint __sudden weight loss __thirsty __lack of thirst__high cholesterol __thyroid disorder __high blood pressure __low blood pressure __tremors, imbalance __sadness/grief __restless legs at night __joint stiffness __brain fog __asthma

_____

WOMEN:

Menarche (first period)_____ Are you pregnant?_____Trying?_____
Menopause pre? post?_____ Number of pregnancies_____Live births_____
How many days in cycle?_____ Number of live births_____Abortions_____
How many days of flow?_____ Date of Last exam/results_____
Heavy/med/light flow?_____ Pap_____Mammogram_____Bone density_____
Clotting_____Colour_____ Cramps when?where?_____Dull/sharp cramps?_____
What relieves the cramping pain? Do you take any meds for this?_____

___discharge __what colour ___vaginal dryness ___nausea ___headache ___bloating
___constipation ____diarrhea ____swollen breasts ___ravenous appetite ___ no appetite
__hot flashes __insomnia __mood swings __night sweats ___^libido __v libido

MEN:

Date of last prostate exam_____PSA results_____Frequency of urination_____
Urine colour_____Delayed stream_____Dribbling_____Retention_____
Impotence_____Groin aches_____Testicular pain_____Back pain_____
Premature ejaculation_____Rectal dysfunction_____
Any other concerns_____
_____