



Lotus Moon Acupuncture and Oriental Medicine

Health History and Questionnaire

Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they play a major role in diagnosis and treatment. All of the information is strictly confidential.

Date: _____ Email: _____

Name: _____ Date of Birth: ____/____/____ Age: _____

Gender: Male Female Social Security Number: _____ - _____ - _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Height: _____ Weight: _____ Family Physician: _____ Last Seen: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Referred By: _____

Relationship Status: Single Married/Life Partner Divorced/Separated Widowed

Have you been treated by Acupuncture or Oriental Medicine in the past? Yes No

What is/are the main problem(s) you would like help with? _____

How long ago did this problem begin? _____ What kinds of treatments have you tried? _____

Have you been given a diagnosis for this problem? If so, what? By whom? _____

To what extent does this problem interfere with our daily activities? _____

Past/Current Medical History:

<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Asthma/Pneumonia	<input type="checkbox"/> Anemia

Other (include chronic illnesses): _____

Surgeries, significant traumas, and/or hospitalizations (type and date): _____

Are you currently pregnant? Yes No How many weeks? _____ What is your due date? _____

Allergies (drug, chemical, food): _____

Medications/Supplements taken within the last two months: _____

Check any of the following that have occurred in your blood relatives:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Allergies	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Obesity	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Nervous System Disease	<input type="checkbox"/> Arteriosclerosis
<input type="checkbox"/> Stroke	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Other: _____

Do you exercise regularly? Yes No Type of exercise: _____

How many cigarettes smoked per day: _____ How much nicotine chewed per week: _____

How many alcoholic drinks per week: _____ How many caffeinated drinks per day: _____

Please describe any use of drugs for non-medical purposes: _____

Please Check any symptom(s) you have had in the last three months:

General:

<input type="checkbox"/> Sudden energy drop	<input type="checkbox"/> Localized weakness	<input type="checkbox"/> Fevers	<input type="checkbox"/> Chills	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Poor Sleep
<input type="checkbox"/> Sleep disorders	<input type="checkbox"/> Sweat easily	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Tremors	<input type="checkbox"/> Poor balance	<input type="checkbox"/> Weight gain
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Bleed/bruise easily	<input type="checkbox"/> Edema (where): _____			
<input type="checkbox"/> Pain: Where: _____		Time of day: _____		Level (1 - 10) _____	
<input type="checkbox"/> Energy level (1 - 10) _____					

Head, Eyes, Ears, Nose, and Throat:

<input type="checkbox"/> Dizziness	<input type="checkbox"/> Migraines	<input type="checkbox"/> Facial Pain	<input type="checkbox"/> Headaches (when & where): _____
<input type="checkbox"/> Glasses	<input type="checkbox"/> Poor Vision	<input type="checkbox"/> Night Blindness	<input type="checkbox"/> Blurry Vision
<input type="checkbox"/> Blind Field	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Spots in front of eyes/floaters
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Eye Dryness	<input type="checkbox"/> Excessive tearing	<input type="checkbox"/> Discharge from eyes
<input type="checkbox"/> Hearing Aids	<input type="checkbox"/> Earaches	<input type="checkbox"/> Poor Hearing	<input type="checkbox"/> Discharge from ears
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Sinus Congestion	<input type="checkbox"/> Nasal Drainage
<input type="checkbox"/> Grinding Teeth	<input type="checkbox"/> Dental Problems	<input type="checkbox"/> Jaw Clicks	<input type="checkbox"/> Loss of Consciousness
<input type="checkbox"/> Concussions	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Recurrent sore throat	<input type="checkbox"/> Sores on lips or tongue
<input type="checkbox"/> Other head or neck problems: _____			

Skin and Hair:

<input type="checkbox"/> Rashes	<input type="checkbox"/> Itching	<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hives	<input type="checkbox"/> Changes in hair or skin
<input type="checkbox"/> Pimples	<input type="checkbox"/> Recent Moles	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Loss of hair	<input type="checkbox"/> Foot Fungus	<input type="checkbox"/> Oozing of skin lesions
<input type="checkbox"/> Other hair, skin, or foot problems: _____					

Cardiovascular:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Chest Discomfort/Pain	<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Swelling of hands	<input type="checkbox"/> Swelling of feet	<input type="checkbox"/> Fainting
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Other heart or blood vessel problems: _____		

Respiratory:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Cough	<input type="checkbox"/> Asthma/Wheezing	<input type="checkbox"/> Pain with deep breathing	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Difficulty Inhaling	<input type="checkbox"/> Difficulty Exhaling	<input type="checkbox"/> Coughing blood
<input type="checkbox"/> Production of phlegm (what color?): _____		<input type="checkbox"/> Other lung problems: _____		

Musculo-Skeletal:

- | | | | | |
|--|--|--------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Hand/Wrist Pain |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Foot/Ankle Pain | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Other muscular/skeletal problems: _____ | | | | |

Urinary:

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Profuse Urination | <input type="checkbox"/> Retention of urine |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Decrease in flow | <input type="checkbox"/> Dribbling | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Waking to urinate |
| <input type="checkbox"/> Other genital/urinary problems: _____ | | | | |

Diet/Gastrointestinal:

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> Peculiar taste or smell | <input type="checkbox"/> Strong thirst | <input type="checkbox"/> No desire to drink | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Digestive allergies | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Chronic laxative use |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Black stools | <input type="checkbox"/> Abdominal distention | <input type="checkbox"/> Abdomen tense/firm | <input type="checkbox"/> Abdominal pain/cramps |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Epigastric pain | <input type="checkbox"/> Other stomach/intestinal problem |

Psycho-emotional:

- | | | | | | |
|---|---------------------------------------|---|-------------------------------------|--|--|
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Irritability | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Los of control/violence potential | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Easily susceptible to stress | | Have you ever been treated for emotional problems? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Have you ever considered or attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |

Neurological:

- | | | | | | |
|--|-----------------------------------|---|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Weakness | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Vertigo/dizziness | | <input type="checkbox"/> Concussion/loss of consciousness | | | |

Sexual/Genital:

- | | | |
|--|--|---|
| <input type="checkbox"/> Changes in sexual drive | <input type="checkbox"/> Sores on genitals | <input type="checkbox"/> Pain in the genital area |
|--|--|---|

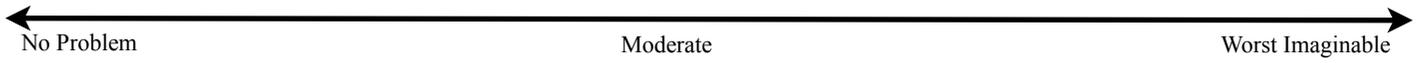
Female:

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Heavy Periods | <input type="checkbox"/> Light Periods | <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Clots |
| <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Vaginal Sores | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Post-coital bleeding |
| Age of first menses: _____ Days between menses: _____ Number of days: _____ First day of last menses: _____ | | | | |
| Color of blood: <input type="checkbox"/> Bright red <input type="checkbox"/> Normal red <input type="checkbox"/> Purple <input type="checkbox"/> Dark brown Date of last pap smear: _____ | | | | |
| Menopause: <input type="checkbox"/> Yes <input type="checkbox"/> No Age: _____ Do you use birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No What type? _____ | | | | |
| # of pregnancies: _____ # of births: _____ # of premature: _____ # of miscarriages: _____ #of abortions: _____ | | | | |

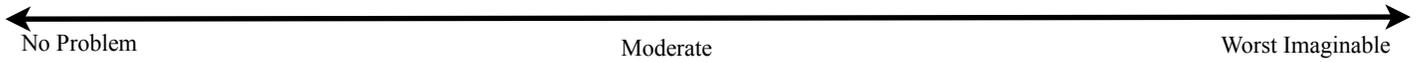
Male:

- | | | | |
|------------------------------------|--|--|--|
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Premature ejaculation/wet dream | <input type="checkbox"/> Other issues: _____ |
|------------------------------------|--|--|--|

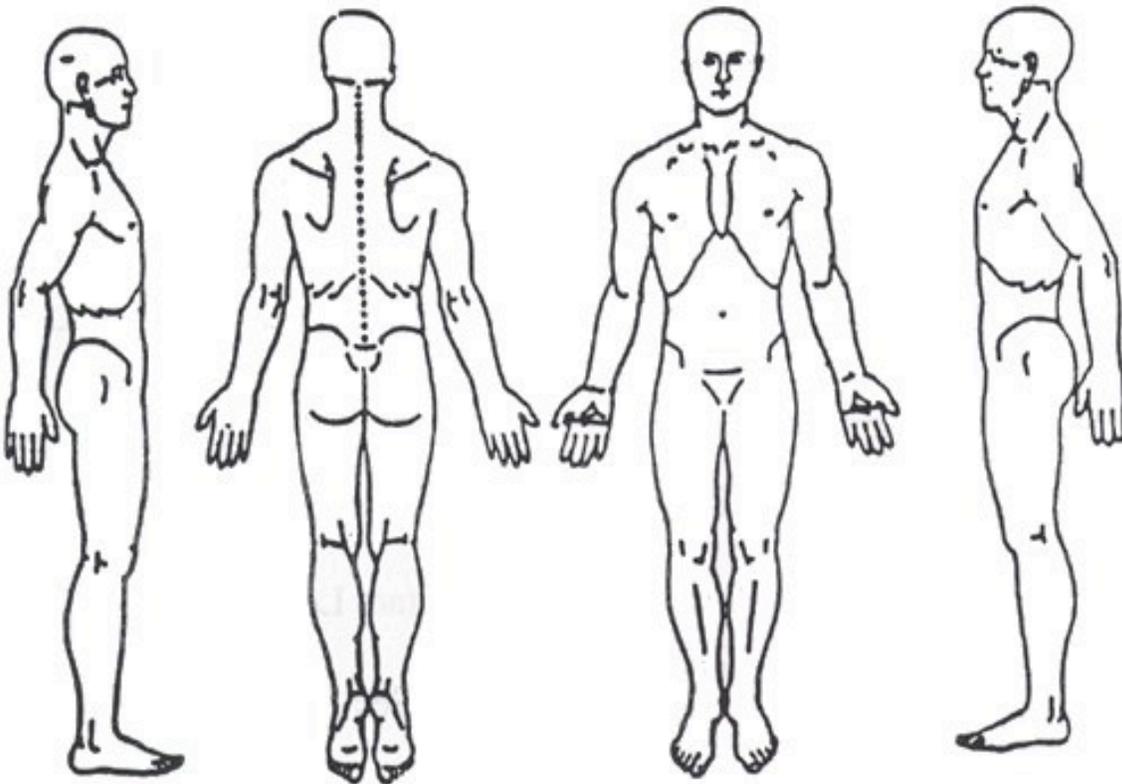
Please note the degree of severity of your main problem now:



Please note the greatest degree of severity of your main problem within the last week:



Please indicate painful or distressed areas with a circle or "X"





Lotus Moon Acupuncture & Oriental Medicine

I, _____, hereby consent to be treated by Mandi Thompson L.Ac., with acupuncture and/or Oriental Medicine procedures, which may include acupuncture, moxibustion, cupping, electrical stimulation, auricular therapy, Tui Na (Chinese Medical massage), Chinese herbal medicine, or nutritional and lifestyle counseling.

I understand that acupuncture is preformed by the insertion of pre-sterilized acupuncture needles through the skin, with or without the addition of heat or electrical stimulation, to certain points on the body, with the intent of improving bodily functions, relieving pain, and treating certain diseases or bodily dysfunctions.

I have been informed that acupuncture, when preformed by qualified licensed practitioners, is a safe method of treatment, but rarely, some side effects can occur. The most common of these are bruising or tingling near the needling site for a few days, fatigue, or temporary aggravation of pre-existing symptoms. Other possible though extremely rare side effects may be fainting, spontaneous miscarriage, or pneumothorax. If I experience any symptoms I believe may be a result of treatment, or if I have questions or concerns regarding my treatments, I've been advised to contact my acupuncturist promptly for guidance.

I understand that I should also inform my acupuncturist prior to being treated if I believe that I might be pregnant.

I accept the fact that no guarantee is made concerning the outcome of my acupuncture or herbal medicine treatments and that I may stop treatments at any time.

PATIENT'S NAME _____

PATIENT'S SIGNATURE _____

ACUPUNCTURIST'S SIGNATURE _____

DATE _____

I, _____ (patient's or patient's representative's name printed), have been advised by Mandi Thompson L.Ac. to consult a physician regarding the condition or conditions for which such patient seeks acupuncture/herbal medical treatment if necessary.

Patient's name

Patient's or patient's representative's signature

Date



Notice of Privacy Practices

Our office is dedicated to providing respectful and confidential services. Protecting your privacy and healthcare information is fundamental to our practice, and is also mandated by law.

Please be advised that we may gather personal and health information about you in several ways:

- ◆ Directly from you, our patient
- ◆ From other healthcare providers
- ◆ From third party payers (i.e., insurance companies)

Not that we may use and disclose medical information about you (without your specific consent or authorization for the following reasons only:

- ◆ To confer with other healthcare practitioners to better understand the optimal course of treatment
- ◆ To facilitate payment from insurance companies for the treatment and services you receive from us
- ◆ To share our findings with your referring primary care practitioners

We may disclose your medical information to any other medical practitioners, friends, or family only with your written consent. You may request a medical information disclosure form from our office.

Communication:

I routinely communicate with patients over the phone to schedule appointments, to address concerns, or answer questions. If I leave a message, I will identify myself by name and mention I am from Lotus Moon Acupuncture. If you prefer to only be contacted at work, home, or other phone number, please write that number here:

Patient Rights:

- ◆ Upon written request, you have the right to access, review, or receive copies of your healthcare records.
- ◆ Upon written request, you have the right to request that I place restrictions on the disclosure of your protected health information. In your request, you must indicate what information you want to limit. I am not required to agree to this request
- ◆ You are entitled to a copy of this notice
- ◆ Upon written request, you have the right to a summary of what I have disclosed about you and to whom.

Complaints:

If you have questions or complaints, please contact Mandi Thompson at (402) 669-2183. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to:

DHHS Division of Public Health Investigations
1033 O Street, Suite 500
Lincoln, NE 68508

*By signing below, I acknowledge that I have read, reviewed, understood, and agreed to the statement of *Privacy Policy* for healthcare services with Lotus Moon Acupuncture. I also confirm that this office has attempted to provide me with a copy of the statement of privacy policies.

(Patient signature)

(Date)



A WORD ABOUT SCHEDULING

I strive to make my office run as smoothly as possible and to help make your experience here as satisfying and pleasant as I can.

To do this, I allow plenty of time for your visit. Unlike many physicians' offices that schedule six to eight patients per hour to compensate for those who do not show up, I regularly see only one or two people per hour. For a first visit, an entire hour and a half is set aside just for you.

To enable me to continue this level of individualized attention, however, I must insist that the time we set aside for you is respected. Consequently, should you be unable to keep your appointment, I require notice of at least 24 hours before your appointment time.

If you forget your appointment, if you are running late and cannot make the appointment, if you have transportation difficulties, or if you call to cancel with less than 24 hours notice, I am obliged to charge you the full fee for the visit. Naturally, I will make an exception to this in the event of genuine emergencies, such as acute illness or accidents. Also, if another time slot is available the same day as your missed appointment, I will gladly switch your time slot with no penalty. If, however, no other time is available that day, you will still be charged for your missed appointment.

This policy is not intended to be punitive. It simply allows me to keep an appointment schedule that favors longer visits. This means my patients spend less time in the waiting room and more time in consultation and treatment with me.

I am grateful for your cooperation and goodwill in this matter.

Sincerely,

Mandi Thompson, L.Ac, LMT

*Please sign below to acknowledge that you have read my scheduling policy and that you accept these terms.
Thank you.*

X _____