

Kim Paquette, L.Ac., LMT
LOTUS SUN THERAPEUTICS

DATE:

Health History Questionnaire

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. If we sincerely believe your condition will not respond satisfactorily, we will not accept your case. If you have any questions, please ask. If you have anything you wish to bring to our attention which is not asked on this form, please note it in the *Comments* section. Thank you.

Name: _____ Date of Birth: _____
Address: _____ Employer: _____
Occupation: _____
Phone: (H) _____ (W) _____
Physician: _____
In Emergency, Notify: _____ Phone: _____

Main problem you would like help with:

When did the problem begin? (Be specific):

To what extent does the problem interfere with your daily activity?

Have you been given a diagnosis for the problem?

What kind of treatments have you tried? _____

PAST MEDICAL HISTORY: (YOURS AND IMMEDIATE FAMILY, PLEASE GIVE DATES)

Cancer: _____ HIV/Aids: _____
Thyroid Disease: _____ Diabetes: _____
High Blood Pressure: _____ Hepatitis: _____
Heart Disease: _____ Seizures: _____
Stroke: _____ Asthma: _____
Other: _____

Surgeries: _____

Significant Traumas: _____

Other: _____

Allergies (drugs, chemicals, foods, etc.):

Occupational Stress (chemical, physical, psychological):

MEDICATIONS:

What medications and/or supplements are you currently taking?

HABITS:

Do you have a regular exercise program? Please describe:

Are you or have you been on a restricted diet? What kind and why?

Please indicate usage per day or week:

Cigarettes _____ **Tea:** _____

Alcohol: _____ **Soft Drinks:** _____

Drugs: _____ **Sugar:** _____

Coffee: _____ **Other:** _____

DO YOU SUFFER FROM ANY OF THE FOLLOWING?

(Check all that apply, and for each if it is current or past)

GENERAL:

- Recurrent infections
- Night Sweats
- Excessive tearing
- Dry skin/scalp
- Bleed/bruise easily
- Strong thirst
- Sore eyes
- Thirst with no desire to drink
- Fatigue
- Sudden energy drops
- Time of day ____
- Head/Eyes/Ears/Nose/Throat
- Pimples
- Sweat easily
- Poor Sleep
- Recent moles
- Changes in hair/skin
- Tremors
- Poor Balance
- Edema
- Weight problems
- Dizziness

- Headaches
- Where _____
- When _____
- Poor hearing
- Ringing in ears
- Eye Pain
- Blurry vision
- Rashes
- Itching
- Eczema
- Glasses
- facial pain
- Hoarseness
- Swollen glands
- Other: _____
- Migraines
- Discharge from ear
- Night blindness
- Color blindness
- Spots in front of eyes
- Nose Bleeds
- Nasal Discharge
- Blocked Nose
- Snoring
- Grinding Teeth
- Teeth problems
- Recurrent sore throat
- Tonsillitis
- Sores on lips/mouth

CARDIOVASCULAR

- Pacemaker
- Low Blood Pressure
- Heart Palpitation
- Swelling of hands or feet
- Spider veins
- other
- High Blood Pressure
- Chest discomfort/pain
- Cold hands or feet
- Blood Clots
- Fainting

RESPIRATORY

- Difficulty breathing
- Shallow breathe
- Shortness of breath
- Pain with breath
- Wheezing/asthma
- Production of phlegm

Color _____
__ Bronchitis __ Recurrent cough
__ Pneumonia

DIGESTION

__ Bad breathe __ Change in appetite __ Nausea
__ Vomiting __ Heartburn __ Indigestion
__ Belching __ Abdominal pain __ Weight gain
__ Weight loss __ Loose stools/Diarrhea __ Constipation
__ Bloody Stools __ Pain with passing stools __ Gas
__ Rectal Pain __ Hemorrhoids
__ Anorexia nervosa __ Bulimia __ Other

GENITO-URINARY

__ Pain with urination __ Urgency __ Bloody urine
__ Frequent urination __ Decrease in flow __ incontinence
__ Unable to hold urine __ Nighttime urination __ Dribbling
__ Kidney stones __ Prostate problems
__ Impotency __ Changes in sex drive __ Rashes

GYNECOLOGICAL

__ # of pregnancies __ # of live births __ # abortions
__ Age of 1st menses _____ __ # days between menses
__ Duration of menses __ Age of menopause
__ Date of last pap
__ PMS __ Irregular periods __ Painful
__ Light periods __ Heavy periods __ Clots
__ Fibroids __ Endometriosis
__ Infertility __ Vaginal discharge __ sores
__ Breast lumps __ Nipple discharge
__ Other

Do you practice birth control?

Yes _____ No _____ If so, what type and for how long?

Are you pregnant now? _____

MUSCULOSKELETAL

__ Neck pain/ache __ Back ache/pain
__ Knee pain __ Shoulder pain
__ Elbow/forearm pain __ Hand/Wrist pain

- | | |
|---|--|
| <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Joint/bone problems |
| <input type="checkbox"/> Torn tissues | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Muscle pain/weakness | |
| <input type="checkbox"/> Hernia | |
| OTHER: _____ | |

NUEROLOGICAL

- | | |
|--|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Nerve damage |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Sleep disorder | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Lack of coordination |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Difficulty in concentrating | |

BEHAVORIAL

- | | |
|--|---|
| <input type="checkbox"/> Moody | <input type="checkbox"/> Easily susceptible to stress |
| <input type="checkbox"/> Aggressive/Bad temper | <input type="checkbox"/> Lose control of emotions |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Extreme Sadness |

Have you ever been treated for emotional problems?

- yes no

COMMENTS:

INFORMED CONSENT FOR ACUPUNCTURE AND CHINESE MEDICINE

I, the undersigned, hereby request and consent to the performance of acupuncture procedures including, but not limited to, moxibustion, cupping, plum blossom, gua sha, electro acupuncture, Tui Na, Massage Therapy, Chinese herbal supplements, on me or the patient for whom I am legally responsible, by my acupuncture practitioner. I recognize

the potential risk and benefit for this procedure as described below:

Potential Risk: discomfort, pain, infection, weakness, fainting, nausea, temporary discoloration at site of procedure, occasional aggravation of symptoms existing prior to treatment.

Potential Benefits: Drugless relief of presenting symptoms and improved balance of the body's energies, which may lead to prevention or elimination of the presenting problems and strengthen the constitution.

I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my presenting conditions for which I seek treatment. I hereby release Lotus Sun Therapeutics and Kimberly Paquette, from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation.

Signature of Patient or Person authorized to consent Date

Print name of Patient or Patients Representative Date

Signature of Witness Date