Lotus Center LLC

410 Ramapo Valley Road
Oakland, NJ 07436
201 – 337 - 0220

HEALTH HISTORY, LIFESTYLE, AND SYMPTOM QUESTIONNAIRE

This is a *confidential* questionnaire to help us determine the best treatment plan for you. If you have any questions, please ask. If you need more room, please use the other side of these sheets.

Name: _____ Date: _____

Home address: _____

City: _____ State: _____ Zip: _____

❑Home(_____)_____ ❑Work(_____)_____❑Cell(_____)_____
Please mark above which number(s) you would prefer to receive messages. Best time to call: _____AM _____PM

Email Address: _____

DOB ___/___/_____ Age: _____ Height: _____ Weight: _____Weight 1 yr ago: _____ Sex: M F

Occupation: _____ Employer: _____

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnership ❑ Same sex relationship

Emergency Contact: _____ Contact phone: _____

Physician Name: _____ Physician phone:_____

How did you hear about the Lotus Center? _____

Have you received acupuncture therapy before? ❑ Yes ❑ No If yes, where?_____

Have you received Chinese Herbal Medicine before? ❑ Yes ❑ No If yes, where? _____

HEALTH HISTORY

1. What are the main health concerns for which you are seeking treatment?

_____ Date of Onset:_____

_____ Date of Onset:_____

_____ Date of Onset:_____

2. What previous medical workups, diagnosis, and treatment have you received for these concerns?

_____

_____

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3. Please list any allergies to: ❑ Latex ❑ Food _____ ❑ Metals _____ ❑ Drugs _____

_____

_____

4. Please indicate if you are taking any of the following:

❑ Blood thinner ❑ Lithium ❑ Pain reliever ❑ Diet pills ❑ Thyroid medication

❑ Sedative ❑ Cortisone/Steroid ❑ Sleeping aids ❑ Laxative ❑ Antacids

5. List any accidents, surgeries, or hospitalizations (include date):

_____

_____

6. Your Current or Past Medical History:

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

❑ AIDS/HIV
❑ Alcoholism
❑ Allergies
❑ Appendicitis
❑ Arteriosclerosis
❑ Asthma
❑ Birth Trauma (your own birth)
❑ Cancer
❑ Chicken Pox
❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Goiter
❑ Gout
❑ Heart Disease
❑ Hepatitis
❑ Herpes
❑ High Blood Pressure

❑ Immunizations (list)
_____
_____
_____
❑ Measles
❑ Multiple Sclerosis
❑ Mumps
❑ Pacemaker
❑ Pleurisy
❑ Pneumonia
❑ Polio
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Seizures
❑ Stroke
❑ Surgery (list)
_____
_____
_____

❑ Thyroid Disorders
❑ Major Trauma (Car, fall, etc.—list)
_____
_____
_____

❑ Tuberculosis
❑ Typhoid Fever
❑ Ulcers
❑ Venereal Disease
❑ Whooping Cough

❑ Other (Specify)
_____
_____
_____
_____

7. Family history – Please check if members of your family have or had:

❑ Allergies ❑ Diabetes ❑ Stroke ❑ Thyroid Disorders
❑ Cancer ❑ Heart Problems ❑ Hypertension ❑ Emotional Difficulties

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LIFESTYLE HABITS

8. Please indicate the use and frequency of the following: (how much, how many, or how often):

❑ Alcohol_____ ❑ Coffee/Tea_____

❑ Tobacco_____ ❑ Soda Pop_____

❑ Marijuana_____ ❑ Water_____

❑ Other Recreational Drugs_____ ❑ Energy Drinks_____

Have you ever been treated for drug/alcohol dependence? ❑ Yes ❑ No

9. Please select the one(s) that most closely describe your diet:

❑ Allergy conscious ❑ Vegan ❑ Vegetarian ❑ Raw foods ❑ High protein

❑ Fast food/Restaurants ❑ Typical American ❑ Ethnic ❑ Low fat ❑ Low carb

Please indicate the use and frequency of the following:

Coffee/Tea_____ Water Intake_____ Alcohol_____

Tobacco_____ Non-Medical Drugs_____ Soda_____

Diet: What might you eat on a typical day? Please list information below in spaces provided.

How many meals do you usually eat per day? _____

How many snacks do you usually eat per day? _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Favorite Foods (cravings): _____

Food Allergies or sensitives: _____

10. What is your daily activity level including your occupation:

❑ Sedentary, i.e. mostly sitting ❑ Very active (moving around or up most of the time)

❑ Somewhat active ❑ Heavy duty (lifting, moving things, etc.)

❑ Moderately active

11. Do you sleep well? ❑ Yes ❑ No Awaken rested? ❑ Yes ❑ No Average hours of sleep : _____

12. What is your average energy level (1=least, 10=most)? 1 2 3 4 5 6 7 8 9 10

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13. What is your average stress level (1=least, 10=most)? 1 2 3 4 5 6 7 8 9 10

14. How much change are you willing to/able to make at this time to improve your health?

❑ Minimal ❑ Some ❑ Complete

15. Do you exercise? ❑ Yes ❑ No

If yes, describe type and frequency: _____

_____

If no, what prevents you: _____

_____

16. Do you have a relaxation practice? ❑ Yes ❑ No

If yes, describe: _____

_____

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SYMPTOM SURVEY

The following is a list of symptoms that you may or may *not* experience. Leave *blank* if you never experience the symptom. Use one check mark **[✓]** to indicate that you experience the symptom **sometimes** and two checkmarks [✓✓**]** if you experience it **frequently**.

General
[ ] Fatigue
[ ] Poor memory
[ ] Prefer cold drinks
[ ] Prefer hot drinks
[ ] Recent weight change
[ ] Cold hands or feet
[ ] Chills
[ ] Fever
[ ] No sweating
[ ] Night sweats
[ ] Excessive sweating
[ ] Muscle cramps
[ ] Lack of strength
[ ] Bodily heaviness
[ ] Vertigo or dizziness
[ ] Bleed easily
[ ] Bruise easily
[ ] Peculiar taste
Describe:_____
[ ] Peculiar smell(nose or body)
Describe:_____
[ ] Frequent colds
[ ] Frequent sore throat
[ ] Frequent earaches
[ ] Frequent fever or flu-like symptoms
[ ] Excessive thirst
[ ] Never thirsty
I drink _____cups of water daily.

Head & Neck
[ ] Stiff neck
[ ] Headaches
[ ] Dizziness
[ ] Fainting
[ ] Swollen glands
[ ] Thyroid issues

Ears
[ ] Ringing in ears
[ ] Hearing loss
[ ] Earache
[ ] Hearing aids
[ ] Vertigo

Eyes
[ ] Glasses/contact lenses
[ ] Glaucoma
[ ] Blurred vision
[ ] Poor night vision
[ ] Spots or floaters
[ ] Double vision
[ ] Itching or burning of eyes
[ ] Cataracts

Nose, Throat & Mouth
[ ] Sinus issues
[ ] Hay fever/ allergies
[ ] Frequent sore throat
[ ] Lump in throat
[ ] Difficulty swallowing
[ ] Excessive saliva
[ ] Mouth, lips, &/or tongue ulcers/sores
[ ] Frequent colds
[ ] Nosebleeds
[ ] Nasal congestion
[ ] Hoarse or raspy voice
[ ] Loss of voice
[ ] TMJ
[ ] Gum problems
[ ] Teeth problems
[ ] Grinding teeth
[ ] Facial pain
[ ] Thirsty
[ ] Dry mouth
[ ] Dry nose

[ ] Dry throat
[ ] Loss of smell

Skin
[ ] Hives / rashes / itching
[ ] Eczema / psoriasis
[ ] Acne
[ ] Dandruff
[ ] Dry skin
[ ] Hair loss
[ ] Changes in moles, lumps
[ ] Fungal infections

Respiratory
[ ] Nasal obstruction
[ ] Difficulty breathing
[ ] Wheezing / asthma
[ ] Cough:
[ ] Wet or [ ] Dry
[ ] Phlegm:
Color: _____
[ ] Shortness of breath
[ ] Tight chest

Cardiovascular
[ ] Phlebitis
[ ] Low blood pressure
[ ] High blood pressure
[ ] Chest pain or tightness
[ ] Palpitations
[ ] Rapid heartbeat
[ ] Irregular heartbeat
[ ] Poor circulation
[ ] Swollen ankles

[ ] Blood clots
[ ] Anemia
[ ] History of heart attack

Gastrointestinal

[ ] Burping / belching
[ ] Nausea / vomiting
[ ] Bad breath
[ ] Indigestion
[ ] Acid regurgitation
[ ] Stomach pain
[ ] Loose stool / diarrhea
[ ] Constipation
[ ] Poor appetite
[ ] Excessive hunger
[ ] Gas / bloating
[ ] Hiccup
[ ] Laxative use
[ ] Bloody stools
[ ] Mucus in stools
[ ] Hemorrhoids
[ ] Gall Bladder disorder
[ ] Intestinal pain or cramping
[ ] Itchy anus
[ ] Burning anus
[ ] Anal fissures

Bowel movements:
Times per day: _____
Color of stool: _____
Texture:
[ ] solid
[ ] loose
[ ] dry
[ ] small
Odor: _____

Musculoskeletal

[ ] Neck pain / tightness
[ ] Joint pain / soreness
[ ] Muscle pain / soreness
[ ] Weak muscles
[ ] Difficulty walking
[ ] Shoulder pain/ soreness
[ ] Upper back pain / soreness
[ ] Low back pain / soreness
[ ] Rib pain / soreness
[ ] Limited range of motion
[ ] Pain while standing
[ ] Pain while sitting
[ ] Pain while walking
[ ] Pain while sleeping
[ ] Pain while turning neck, arm, torso
[ ] Pain going up/down stairs
[ ] Pain upon raising arm
[ ] Swollen joint(s)
[ ] Foot pain / tenderness

Neurological / Emotional

[ ] Muscle weakness
[ ] Tremors
[ ] Numbness or tingling
[ ] Nerve pain
[ ] Paralysis
[ ] Poor coordination
[ ] Seizures
[ ] Tics
[ ] Easily angered
[ ] Easily irritated / frustrated
[ ] Difficulty making decisions
[ ] Phobias
[ ] Fear
[ ] Easily startled
[ ] Tendency to become obsessive
[ ] Mood swings
[ ] Irritability
[ ] Inappropriate laughter
[ ] Memory confusion
[ ] Poor concentration
[ ] Suicidal thoughts
[ ] Frequent crying
[ ] Depression
[ ] Anxiety
[ ] Easily stressed
[ ] Abuse survivor
[ ] Seeing a therapist

Genito-urinary

[ ] Pain on urination
[ ] Frequent urination
  [ ] Night
  [ ] Day
[ ] Urgent urination
[ ] Strong smelling urine
[ ] Blood in urine
[ ] Unable to hold urine
[ ] Incomplete urination
[ ] Bedwetting
[ ] Wake to urinate
[ ] Kidney stones
[ ] Pain / itching of genitalia
[ ] Lumps in testicles
[ ] Frequent infections