Blue Lotus Community Acupuncture Clinic
119 W. 23rd Street, Suite 1000 New York, NY 10011
phone 917 409 6593 www.bluelotusacupuncture.com

Health History & Intake Form

PATIENT INFORMATION

Today's Date_____

Name_____

Address_____

City State Zip_____

Age_____ Date of Birth _____

Occupation _____

Company name _____

Primary physician _____

Physician phone number_____

How did you hear about us?_____

Health insurance name _____

CONTACT INFORMATION

Home phone _____

Work phone _____

Other/cell phone _____

Email _____

Last 4 digits of SSN _____

Another person we may contact if needed:

Name _____

Relationship_____

Home phone _____

Work or Cell phone _____

Would you like to receive our newsletter by email? _____

HEALTH HISTORY

What are your primary reasons for coming in for treatment?

1- _____

2 - _____

3 - _____

List medications or vitamin supplements you are taking and why:

1)

2)

3)

4)

5)

6)

List serious illnesses, accidents or surgeries:

_____

_____

Check illnesses that have occurred in blood relatives.

Diabetes High blood pressure Stroke
Cancer Heart disease Kidney disease

Check symptoms you have or have had in the last year:

- □ Depression/Anxiety
- □ Difficulty in focusing
- □ Dizziness
- □ Easily startled
- □ Excessive worry
- □ Excessive anger
- □ Excessive fear
- □ Fatigue/tiredness
- □ Headaches
- □ Loss of sleep/poor sleep
- □ Loss or gain of weight
- □ Nervousness/irritability
- □ Overwhelmed by life

Check conditions you have or have had in the past:

- □ AIDS
- □ Allergies
- □ Anemia
- □ Arthritis
- □ Bleeding disorders
- □ Breast lump
- □ Cancer _____
- □ Diabetes
- □ Hepatitis A, B, or C

How long has it been since you have had a complete medical exam/physical? _____

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HEALTH HISTORY…CONTINUED

Check symptoms you ***have or have had*** in the last year:

MUSCLE/JOINT/BONES
- □ Tremors or Cramps
- □ Swollen joints: _____

Pain, weakness, numbness in (indicate which one):
- □ Arms or Hips
- □ Back Legs
- □ Feet
- □ Neck
- □ Hands/fingers
- □ Shoulders
- □ Other_____

EYES/EAR/NOSE/THROAT/RESPIRATORY
- □ Asthma/wheezing
- □ Blurred or failing vision, floaters
- □ Difficulty breathing
- □ Earache
- □ Enlarged lymph nodes (glands)
- □ Eye pain or dry eyes
- □ Frequent colds
- □ Hay fever
- □ Hoarseness
- □ Gum trouble
- □ Nose bleeds
- □ Loss of hearing
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems/pain

SKIN
- □ Boils
- □ Bruise easily
- □ Dry skin
- □ Itching/rash
- □ Sensitive skin
- □ Sores that do not heal
- □ Sweats: Night-sweats or cold sweats

GENITO/URINARY
- □ Blood/pus in urine
- □ Frequent urination
- □ Inability to control urine
- □ Kidney infection/stones
- □ Burning Urination or UTI

CARDIOVASCULAR
- □ Chest pain
- □ Hardening/blockage of arteries
- □ High or low blood pressure
- □ Pain over heart
- □ Poor circulation
- □ Previous heart attack
- □ Rapid/irregular heart beat
- □ Swelling of ankles or hands

GASTROINTESTINAL
- □ Belching, gas or bloating
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ Distention of abdomen
- □ Excessive hunger
- □ Gall bladder stones
- □ Hemorrhoids (piles)
- □ Indigestion/acid reflux
- □ Nausea
- □ Pain over stomach
- □ Poor appetite
- □ Vomiting

FOR MEN ONLY
- □ Erection dysfunction
- □ Discharge
- □ Prostate trouble
- □ Low libido

FOR WOMEN ONLY
- □ Bleeding between periods
- □ Clots in menses
- □ Excessive menstrual flow
- □ Extreme menstrual pain
- □ Irregular cycle
- □ Menopausal symptoms
- □ PMS
- □ Previous miscarriage
- □ Short or long period
- □ Low libido

Could you be pregnant?_____

SIGNATURE

The information on this form is true and correct to the best of my knowledge.

Signature_____ Date _____