

# Lotus Center of Oriental Medicine

907 Irwin Street San Rafael California 94901  
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Email address: info@lotuscenteroriental.com  
www.lotuscenteroriental.com

**WELCOME TO OUR OFFICE!!!**

**Your first appointment is scheduled for \_\_\_\_\_**

***If you need to change this date and/or time for any reason,  
please contact our office at least 24 hours in advance.***

It is our goal at the Lotus Center to help you achieve the best possible results from your experience with us. For this reason, we would like you to note the following guidelines for before and after your acupuncture treatment:

## **BEFORE ACUPUNCTURE**

Please leave your complexion and scent natural until after your office visit. Avoid heavy meals, caffeine, exercise and stimulants. Avoid taking a very hot or cold bath, shower or swim within a 1 to 2 hour period prior to your treatment.

Allow enough time to arrive here relaxed, and leave enough time to relax a bit afterwards. If you have a time constraint, please advise us and we will do our best to have you out on time.

Please bring a list of all medications and supplements you are currently taking. If you have any questions please write them down, and bring them with you.

## **AFTER ACUPUNCTURE**

Avoid heavy meals, and/or vigorous exercise for 1 to 2 hours after treatment. Try to rest, or take it easy to give the treatment time to do its work. It is important to drink plenty of fluids to stay hydrated after an acupuncture treatment.

*Follow the instructions given to you. "Do your homework, and take your herbs."*

If you have any questions please feel free to call. That is why we are here.

## **OFFICE HOURS**

MONDAY : by appointment depending on availability  
TUESDAY : 9:30am - 5:30pm  
WEDNESDAY: 9:30am - 5:30pm  
THURSDAY : 9:30am - 5:30pm  
FRIDAY : 9:00am - 3:30pm  
SATURDAY : by appointment depending on availability

***We have a strict 24 hour cancellation policy***

# OFFICE PROCEDURE & PATIENT INTRODUCTION

This clinic specializes in acupuncture care. We ask you to fill out this form for either consultation or examination purposes. Examinations are done routinely to determine the nature and extent of your problems. The acupuncturist will explain the level of examination necessary for your condition.

Full name \_\_\_\_\_ Birth date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
Drivers license # \_\_\_\_\_ S.S. # \_\_\_\_\_ Email \_\_\_\_\_  
Marital status \_\_\_\_\_ Number of children \_\_\_\_\_ Referred by \_\_\_\_\_  
Employer name & address \_\_\_\_\_

Complaints or existing conditions \_\_\_\_\_  
Complaints secondary to condition \_\_\_\_\_  
Current or previous doctor's name, specialty, phone # \_\_\_\_\_

Diagnosis by your doctor \_\_\_\_\_  
Specific purpose of visit \_\_\_\_\_

What type of service do you desire?

- Balanced optimum health care – elimination of root cause of problem.
- Maintenance care – regular balancing/tune ups to maintain good health.

How would you classify your condition?

- Minor
- Involved
- Fairly severe and progressively getting worse.
- Serious

Check the conditions listed below only if the answer is yes.

Tendency to faint	Bruise or discolor easily	Bleed easily
Have hepatitis	Have AIDS / HIV	Have high blood pressure
Any heart problems	Any respiratory problems	Had acupuncture before
Previous surgery	Taking medications	Receiving any other treatment
Are you hungry	Tired	Nervous

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this acupuncture office will prepare any necessary reports or forms needed for payment collection from my carrier. My account will be credited with any payment received by this office directly from my carrier. I understand and agree that all services rendered me are charged to me and I am personally responsible for payment. I also understand that upon suspension or termination of services, all fees will be immediately due and payable.

Person responsible for account \_\_\_\_\_

The above statements by me are accurate to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# DESCRIPTION OF COMPLAINT

Name \_\_\_\_\_ Date \_\_\_\_\_

Purpose of visit: \_\_\_\_\_

Major complaint: \_\_\_\_\_

How did this condition develop? (What was the cause?)

When were you first aware of this condition? \_\_\_\_\_

Have you had this condition, or a similar condition before? If yes please explain:

Have you received any treatment for this condition? YES NO

If yes, please give detail as to:

When \_\_\_\_\_ Where \_\_\_\_\_ By whom \_\_\_\_\_

What was the diagnosis? \_\_\_\_\_

What were the results of the treatment? \_\_\_\_\_

Has the condition been getting Better Same Worse

Are you experiencing physical, mental or emotional stress at: Home Work Other

How has this condition affected the following?

Home life: Better Same Worse

Work experience: Better Same Worse

Social life: Better Same Worse

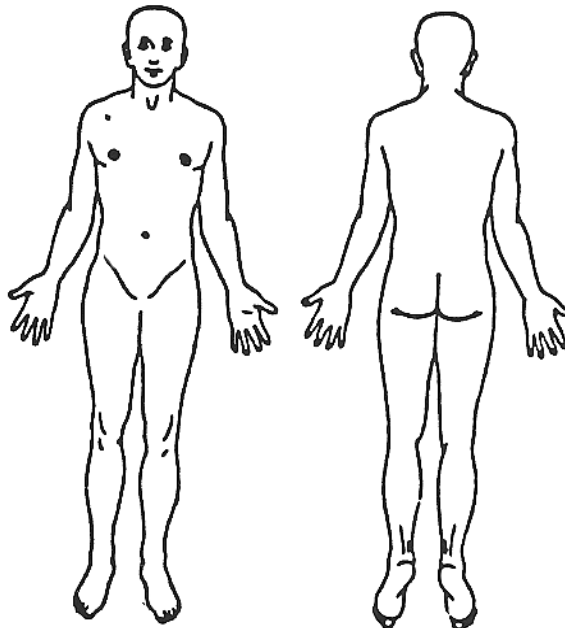
Ability to exercise: Better Same Worse

Ability to rest or sleep: Better Same Worse

Other \_\_\_\_\_

Please list any injuries you have had, related or otherwise, to your condition:

***If you are in pain, please mark the location of your pain on the figures below. Describe the type, frequency, intensity, and duration of your pain. Please indicate any activity that brings on or aggravates your pain.***



# PATIENT PROFILE

Name \_\_\_\_\_ Date \_\_\_\_\_

It is very important in Chinese medicine to know how long a patient has experienced his/her symptoms. Therefore, it is essential to indicate the frequency of your symptoms.

*Indicate with one check mark any condition that you occasionally experience. Use two check marks for those that occur often. Use three check marks for symptoms that are a major concern.*

## WATER ELEMENT

- Hearing loss
- Dizziness
- Back ache / neck pain
- Sinus congestion
- Edema
- Darkness under eyes
- Emotional instability
- Aversion to cold
- Hair loss or thinning
- Pre-mature aging
- Frequent urination
- Kidney stones
- Perspire easily
- Weakness of legs/knees
- Asthmatic cough
- Rapid weight change
- Loose teeth
- Reduced sexual energy
- Thyroid problems
- Diabetes

## WOOD ELEMENT

- Headaches
- Migraines
- ringing in the ears
- Poor eyesight
- Eye infections
- Dry eyes
- Eczema
- Shingles
- Herpes simplex
- Warts
- Nervousness
- Convulsion/spasms
- Irritability
- Constipation
- Hemorrhoids

- Hepatitis
- Ulcer
- Vomiting
- Gallstones
- Indecisive
- Fullness below ribs
- Shoulder/neck tension
- Insomnia 11PM-3AM

## FIRE ELEMENT

- Dry scalp
- Skin eruptions/rashes
- Cysts/tumors
- Ear infections
- Sore throat/tonsillitis
- Lymphatic swelling
- Hot palms/soles
- Heart palpitations
- Aversion to heat
- Bitter taste in mouth
- Gum problems
- Nose bleed
- Facial redness
- Itching/burning skin
- Hot hands/feet
- Thirst
- Vivid dreaming
- Dark urine
- Night sweats

## EARTH ELEMENT

- Indigestion
- Flatulence
- Food allergy
- Stomach ache/ulcer
- Diarrhea
- Anemia
- Halitosis

- Mouth sores
- Heartburn
- Strong appetite
- Weak appetite
- Nausea
- Abdominal bloating
- Low body weight

## METAL ELEMENT

- Bronchitis
- Asthma
- Shallow Breathing
- Cough
- Sinus congestion
- Nasal Infections

## OTHER

- Fatigue
- Arthralgia
- Sciatica/nerve pain
- Cold hands/feet
- Tendonitis
- Bursitis

## PAIN

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## LIST MEDICATIONS

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## OTHER COMMENTS

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**CHECK INDICATES CURRENT AND/OR FORMER CONDITIONS**

Please mark a "C" for current, "F" for former or "B" for both next to checked circle

Also indicate duration, frequency, intensity and pain beside current conditions.

**GENERAL CONDITIONS**

- Tremors
- Headache
- Fever
- Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of sleep
- Fatigue
- Nervousness
- Depression
- Loss of weight
- Forgetfulness
- Numbness or pain in arms, hands, elbows of shoulders.
- Numbness or pain in hips, legs, knees or feet.
- Confusion
- Paralysis

**EYES & EARS**

- Failing vision
- Near sightedness
- Eye pain
- Eye strain
- Cross eyed
- Eye inflammation
- Glaucoma
- Deafness
- Earache
- Ear discharges
- Ear noises

**NOSE & THROAT**

- Nose bleeds
- Nasal obstruction
- Nasal drainage
- Loss of smell
- Sinus infection
- Hay fever
- Allergies
- Sore throat / hoarseness
- Pain near stomach

- Difficult speech
- Difficult swallowing
- Loss of taste
- Change in taste
- Dental decay
- Gum problems
- Tonsillitis
- Asthma
- Frequent colds
- Enlarged thyroid
- Enlarged glands

**SKIN**

- Skin eruptions
- Clammy skin
- Dryness
- Bruise easily
- Boils
- Rashes
- Sensitive skin
- Hives
- Skin allergies

**RESPIRATORY**

- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Difficulty breathing
- Wheezing

**CARDIOVASCULAR**

- Rapid heart beat
- Slow heart beat
- Irregular heart beat
- High blood pressure
- Low blood pressure
- Pain near heart
- Previous heart attack
- Hardening of arteries
- Swelling of ankles
- Poor circulation
- Paralytic stroke

- Varicose veins

**MUSCLES AND JOINTS**

- Stiff neck
- Shoulder pain
- Back pain
- Painful tail bone
- Foot trouble
- Hernia
- Spinal curvature
- Bad posture
- Swollen joints
- Stiff joints
- Arthritis
- Sore muscles
- Weak Muscles
- Problems with walking
- Sciatica

**GENITOURINARY**

- Frequent urination
- Scanty urine
- Painful urination
- Blood in urine
- Pus in urine
- Kidney infection
- Kidney stones
- Bed wetting
- Inability to control urine
- Prostrate trouble
- Bladder problems
- Foul smelling urine
- Discolored urine

**GASTROINTESTINAL**

- Poor appetite
- Excessive hunger
- Difficulty chewing
- Excessive belching
- Nausea
- Gas
- Vomiting
- Vomiting blood
- Abnormal bleeding

Distended abdomen

Constipation

Diarrhea

Black stool

Blood in stool

Colon trouble

Hemorrhoids

Intestinal worms

Liver trouble

Gall bladder trouble

Jaundice

Colitis

Weight trouble

### **FEMALE**

Excessive flows

Hot flashes/night sweats

Irregular cycle

Cramps of back ache

Previous miscarriage

Vaginal discharge

Vaginal pain

Congested breast

Breast pain

Lumps in breast

Menopausal symptoms

Last period

Reduced sexual energy

Pregnancy

Pregnancy complications

### **MALE**

Genital pain

Reduced sexual energy

Premature ejaculation

Seminal emission

Impotence

Discharges

## **PAST MEDICAL HISTORY**

Anything significant about your birth?

Any allergies or reactions to vaccines or medications?

Any surgery, accidents, or major illnesses? Please indicate length and severity.

AGE 0-6

AGE 7-12

AGE 13-20

AGE 21-30

AGE 31-40

AGE 40-PRESENT

Name \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT'S CONSENT FOR THE PURPOSES OF TREATMENT,  
PAYMENT, AND HEATHCARE OPTIONS**

I, (please print name) \_\_\_\_\_ give consent to The Lotus Center of Oriental Medicine, the use and disclosure of my individual identifiable health information or Protected Health Information for the specific purposes:

1. Providing treatment to me.
2. Relating to the payment of the services this office has rendered to me.
3. The general administrative operations this practice provides to me.

**The purpose of this consent:**

Protected Health Information is any information including:

1. Demographic information.
2. Information gathered by this practice as it related to my past, present and future physical or mental health condition.
3. Information gathered by this office for past, present or future payments for providing the healthcare services.
4. Healthcare operations purposes will include quality assessment activities, credentialing, business management and other general operations procedures or activities.

I understand I have the right to request restriction on the use and disclosure of my protected Health Information for the purposes of treatment, payment of healthcare operations of the Acupuncture practice, but the practice is not required to agree to these restrictions. However, if the practice agrees to a restriction that I request, the restriction is binding on the practice.

**I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form from this Acupuncture Practice before I sign this consent regarding the use and disclosures of my Protected Health Information.**

I have the right to revoke this consent, in writing, at any time except that the Acupuncturist or the Practice has acted in reliance on this consent.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description or Personal Representative's Authority

\_\_\_\_\_  
Date

**ACKKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, (please print name)\_\_\_\_\_ have read, reviewed, understand and agree to the statement of the Privacy Policy for the healthcare services in this office:

**The Lotus Center of Oriental Medicine  
Stephanie A. Lum R.C.P., L.Ac., O.M.D.  
907 Irwin Street  
San Rafael California 94901**

This Practice has attempted to provide each patient with a statement of policies.

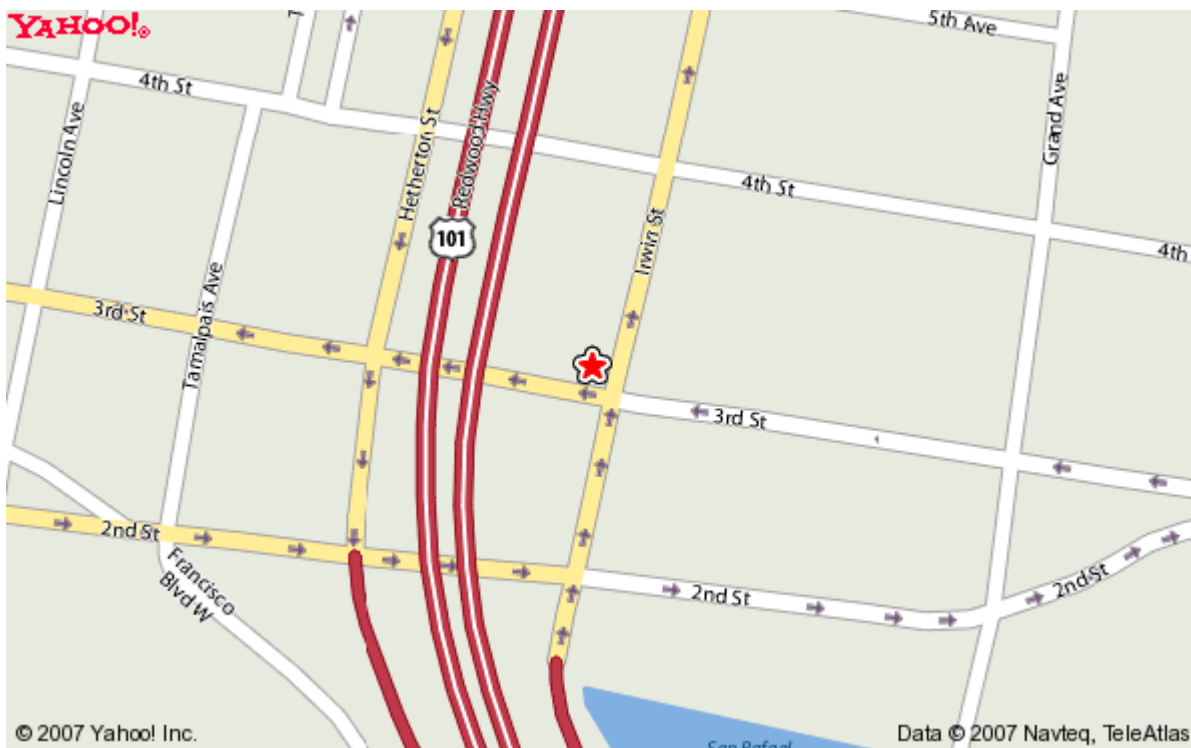
Patient Signature\_\_\_\_\_Date\_\_\_\_\_

## **PARKING INFORMATION FOR NEW CLIENTS:**

There is parking behind our complex directly underneath the 101 freeway. The entrance is from 4<sup>th</sup> street. Be sure to park in the section marked “French Quarter 3 Hour Parking”. If it is full, try the surrounding streets. There is usually parking on 4<sup>th</sup> street, just east of Irwin.

If you do park on the surrounding streets, please be aware of posted time restrictions and tow zones.

If you are unfamiliar with the area, please allow some extra time to find parking, in order to arrive at your appointment on time.



Thank you,

The Lotus Center