New Acupuncture Patient Form

On the following pages, you will find quite an extensive questionnaire. Compared to many medical disciplines, which are interested only in information pertaining to their specialty, traditional Chinese medicine (TCM) considers your body as a holistic system, having physical and emotional components. Having more complete information allows your provider to make a more complete diagnosis and provide you with a more comprehensive treatment.

Please fill out as much of the form as feels comfortable to you. If you do not feel comfortable disclosing particular information, skip that part. At your first meeting, your acupuncturist will go over the information you provide and you can ask any questions you may have. We realize that acupuncture is often new and unfamiliar, and questions are welcome, especially yours. If this is your first experience with acupuncture and TCM, we predict you will be pleasantly surprised.

Thank you for allowing Green Lotus to be part of your health care team.

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Acupuncture Patient Information

Name_____ Date of Birth_____

Phone_____ Email_____

Address_____

City_____ State_____ Zip_____

Pronoun Preference _____ Occupation _____

Emergency Contact _____ Emergency Contact Phone _____

Primary Physician _____ Phone _____

Main Health Concern/s
Please list in order of significance to you

1._____ Date of onset _____

Cause, if known_____

What makes it better? _____

What makes it worse? _____

Past treatment/s _____

2. _____ Date of onset _____

Cause, if known_____

What makes it better? _____

What makes it worse? _____

Past treatment/s _____

3. _____ Date of onset _____

Cause, if known_____

What makes it better? _____

What makes it worse? _____

Past treatment/s _____

Health History

Major Illnesses _____

Significant Trauma (physical and/or emotional) _____

_____

Surgeries/Hospitalizations _____

Known Stressors (occupational, lifestyle, etc.) _____

Height _____ Weight _____ lbs. Max Weight _____ lbs. When? _____

Is there anything else you'd like to share? _____

_____

Lifestyle
Please circle and describe

Do you eat 3 meals per day?	Yes	No	
Are your meals relaxed?	Yes	No	
Do you eat while driving, working, standing, etc.?	Yes	No	
Do you drink caffeinated beverages?	Yes	No	How much? _____

Describe your typical foods _____

_____

Do you exercise regularly?	Yes	No	

Describe your exercise routine and frequency _____

_____

Do you use tobacco?	Yes	No	How long? _____ Packs per day ____
Are you a former tobacco user?	Yes	No	How long? _____ Packs per day ____
Do you drink alcohol?	Yes	No	How much? _____
Do you use cannabis?	Yes	No	How much? _____
Have you been treated for substance use disorder?	Yes	No	When? _____

Family Health History
Please fill in age and if applicable, indicate health history with a checkmark

Condition	Father	Mother	Brother	Sister	Child	Spouse
Age, if Living						
Age, at Death if Deceased						
Overall Health: G=Good; P=Poor						
Cause of Death						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Health Concerns						
Asthma, COPD, Lung Conditions						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						

Childhood Illnesses
Please indicate health history with a checkmark

Scarlet Fever	
Mumps	
Chicken Pox	
Diphtheria	
Measles	
German Measles	
Pneumatic Fever	

Immunizations
Please circle

Measles/Mumps/Rubella	Yes	No
Tetanus	Yes	No
Pertussis	Yes	No
Polio	Yes	No
Diphtheria	Yes	No
Hepatitis B	Yes	No
Influenza (Date _____)	Yes	No
Covid (Date _____)	Yes	No

Allergies & Sensitivities
Please circle and list

Medications? Yes No

Please list: _____

Foods? Yes No

Please list: _____

Environmental? Yes No

Please describe: _____

Medications & Supplements
Please list current prescriptions, over-the-counter medications, and supplements

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Symptom Profile

Check "now" for a symptom you have currently; check "past" and indicate when for a symptom you've had previously.

Skin & Hair	***Now***	***Past***	***When?***
Acne, Boils	☐	☐	_____
Acute Hair Loss	☐	☐	_____
Color/Texture Changes	☐	☐	_____
Eczema, Psoriasis	☐	☐	_____
Hives, Allergies, Rash	☐	☐	_____
Dandruff	☐	☐	_____
Nail Fungus	☐	☐	_____
Other _____	☐	☐	_____

Respiratory	***Now***	***Past***	***When?***
Asthma, Wheezing	☐	☐	_____
Bronchitis	☐	☐	_____
Chest Tightness	☐	☐	_____
Chronic Cough	☐	☐	_____
COPD, Emphysema	☐	☐	_____
Frequent Colds	☐	☐	_____
Painful Breathing	☐	☐	_____
Pneumonia	☐	☐	_____
Shortness of Breath	☐	☐	_____
Sinus Congestion	☐	☐	_____
Spitting Up Blood	☐	☐	_____
Temporary Cough	☐	☐	_____
Tuberculosis	☐	☐	_____
Other _____	☐	☐	_____

Urinary & Kidney	***Now***	***Past***	***When?***
Frequent Infection	☐	☐	_____
Waking to Urinate	☐	☐	_____
Incontinence	☐	☐	_____
Painful Urination	☐	☐	_____
Urgent Urination	☐	☐	_____
Blood in Urine	☐	☐	_____
Kidney Stones	☐	☐	_____
Other _____	☐	☐	_____

Musculoskeletal	***Now***	***Past***	***When?***
Back Pain - Upper	☐	☐	_____
Back Pain - Middle	☐	☐	_____
Back Pain - Lower	☐	☐	_____
Sciatica	☐	☐	_____
Hip Pain	☐	☐	_____
Neck Pain	☐	☐	_____
Shoulder Pain	☐	☐	_____
Elbow Pain	☐	☐	_____
Knee Pain	☐	☐	_____
Wrist Pain	☐	☐	_____
Ankle Pain	☐	☐	_____
Arm Pain	☐	☐	_____
Leg Pain	☐	☐	_____
Hand Pain	☐	☐	_____
Foot Pain	☐	☐	_____
Rib Pain	☐	☐	_____
Fibromyalgia	☐	☐	_____
Other Pain	☐	☐	_____
Location _____			
Weakness	☐	☐	_____
Location _____			
Reduced Range of Motion	☐	☐	_____
Location _____			
Limited Use	☐	☐	_____
Describe _____			
Muscle Spasms or Cramps	☐	☐	_____
Describe _____			
Broken Bones	☐	☐	_____
Location _____			
Other _____	☐	☐	_____
Describe _____			

Eye, Ear, Nose & Throat	***Now***	***Past***	***When?***
Cataracts	☐	☐	_____
Color Blindness	☐	☐	_____
Contacts or Glasses	☐	☐	_____
Double Vision	☐	☐	_____
Eye Pain or Strain	☐	☐	_____
Glaucoma	☐	☐	_____
Impaired Vision	☐	☐	_____
Eye Tearing or Dryness	☐	☐	_____
Vision Spots or Floaters	☐	☐	_____
Ear Ringing/Tinnitus	☐	☐	_____
Loss of Hearing	☐	☐	_____
Recurring Ear Infections	☐	☐	_____
Nose Bleeds	☐	☐	_____
Loss of Smell	☐	☐	_____
Post-Nasal Drip	☐	☐	_____
Bleeding Gums	☐	☐	_____
Dry Mouth	☐	☐	_____
Mouth Sores	☐	☐	_____
Teeth Grinding	☐	☐	_____
TMJ, Jaw Problems	☐	☐	_____
Goiter	☐	☐	_____
Hoarseness	☐	☐	_____
Swollen Glands	☐	☐	_____
Trouble Swallowing	☐	☐	_____
Frequent Sore Throat	☐	☐	_____
Feels like there is a lump in throat	☐	☐	_____
Other _____	☐	☐	_____

Cardiovascular	***Now***	***Past***	***When?***
Heart Disease	☐	☐	_____
Chest Pain	☐	☐	_____
Heart Murmur	☐	☐	_____
Palpitations/Fluttering	☐	☐	_____
High Blood Pressure	☐	☐	_____
Low Blood Pressure	☐	☐	_____
Irregular Heartbeat	☐	☐	_____
Tachycardia	☐	☐	_____
Phlebitis	☐	☐	_____
Blood Clots	☐	☐	_____
Ankle Swelling	☐	☐	_____
Fainting	☐	☐	_____
Other _____	☐	☐	_____

Digestive	***Now***	***Past***	***When?***
Nausea	☐	☐	_____
Vomiting	☐	☐	_____
Loss of Appetite	☐	☐	_____
Ulcer	☐	☐	_____
Heartburn, GERD	☐	☐	_____
Bad Breath/Taste	☐	☐	_____
Gas, Bloating	☐	☐	_____
Cramping	☐	☐	_____
Constipation	☐	☐	_____
Diarrhea, Loose Stool	☐	☐	_____
Rectal Itching/Burning	☐	☐	_____
Hemorrhoids	☐	☐	_____
Change in Bowel Movements	☐	☐	_____
Other _____	☐	☐	_____

Mind, Emotions & Sleep

	Now	*Past*	*When?*		*Now*	*Past*	*When?*
Anxiety	□	□	_____	PTSD, C-PTSD	□	□	_____
Depression	□	□	_____	Trouble Falling Asleep	□	□	_____
ADHD, ADD	□	□	_____	Trouble Staying Asleep	□	□	_____
Stress	□	□	_____	Nightmares, Disturbed Sleep	□	□	_____
Irritability	□	□	_____	Considered/Attempted Suicide	□	□	_____
Poor Memory	□	□	_____	Abuse Survivor	□	□	_____
Mood Swings	□	□	_____	Seeing a Therapist	□	□	_____
Intrusive Thoughts, OCD	□	□	_____	I do not feel safe at home	□	□	_____

Other _____

_____

Is there anything else you'd like your acupuncturist to know?
Please describe additional health history, list concerns or questions, or use the space below to communicate anything else you'd like your acupuncturist to know to make your session as comfortable, safe, effective, and therapeutic as possible.

We are glad you're here.

Consent to Treatment

Please read this entire waiver before agreeing to it at its conclusion:

I understand that healing services - including yoga with its physical movements - provide opportunities for relaxation, stress reduction, relief of muscular tension and stagnant energy in the body, and building muscles, stamina, strength, and more.

If I have underlying medical conditions such as heart disease, diabetes, high blood pressure, or other health concerns, or if I am pregnant, I will seek the advice of my primary care physician before receiving a healing service, treatment, or taking a class. I will inform Green Lotus about these conditions. I understand that I am welcome to have a manager tour the facilities and equipment in it with me prior to having a healing service, treatment, or taking a class.

I acknowledge that I am the decision-maker for my health and well-being, including receiving integrative healing services and taking yoga and other classes and workshops involving physical movement, education, and training.

I understand that there is an inherent risk of exposure to contagious diseases including COVID-19 in any public place where people are present, and I assume all risks related to exposure. I understand that senior citizens and people with underlying medical conditions are more vulnerable to viruses and other diseases.

If I am experiencing any symptoms of illness, I will cancel appointments and class reservations right away and not attend any healing services or classes until my symptoms resolve. I understand that Green Lotus is asking its community of clients and students to help keep each other healthy. My presence at Green Lotus confirms that I am not experiencing any symptoms, including fever, shortness of breath, dry cough, runny nose, sore throat, or loss of taste or smell.

In addition, I represent and agree as follows:

1. I have been examined by a licensed physician within the past 12 months and **HAVE / HAVE NOT (circle one)** been found by such physician to be in good physical health.
2. I **DO / DO NOT (circle one)** have a pacemaker or bleeding disorder.
3. If I am under 18 years of age, I have disclosed that information to Green Lotus Yoga and Healing Center.
4. I am giving my consent to be treated with acupuncture and traditional Chinese medicine by a licensed professional acupuncturist at Green Lotus Yoga and Healing Center. I understand that my individualized treatment plan will rely on a professional acupuncturist's best judgement and may include acupuncture, moxibustion, cupping, dermal friction or gua sha, acupressure, tui na massage, dietary counseling, breathing techniques, lifestyle guidance, movement therapy, and other advice.
5. I understand that I may refuse any therapy modality as I see fit.
6. Acupuncture / Moxibustion: Acupuncture is performed by inserting thin sterile needles through the skin and moxibustion is the application of heat on or near the skin. I have been informed that the acupuncture performed will meet the standards for Clean Needle Technique (CNT) established by the National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM). I am aware that rare but possible risks of needle insertion include the needle becoming stuck or breaking beneath the skin. I am aware that adverse side effects may result from acupuncture and/or moxibustion. These include, but are not limited to: local bruising, minor bleeding, localized pain, burns, fatigue, nausea, fainting, and infection. Pneumothorax and spontaneous abortion are also possible.
7. Acupressure / Tui Na Massage / Cupping / Dermal Friction and Gua Sha: I understand that I may be offered these physical therapies as part of my treatment. I am aware that adverse side effects may result from treatment. These may include, but are not limited to: redness, bruising, sore muscles, infection, and the temporary aggravation of symptoms.
8. Chinese Herbs: I understand that the acupuncturist may recommend an herbal remedy. If I choose to take the remedy, I understand that I must follow the directions for administration and dosage. I am aware that adverse side effects may result, including, but not limited to: gastrointestinal distress, nausea, and sleep disturbances. If I experience adverse side effects, I will stop taking the remedy and contact my practitioner as soon as possible.
9. I understand that acupuncturists practicing in the state of Minnesota are not primary care providers and do not make Western medical diagnoses. The acupuncturist may refer me to seek diagnoses by a licensed physician and I understand it is my responsibility to obtain these diagnoses.

I accept that I am signing a legal document and releasing Green Lotus Group, LLC dba Green Lotus Yoga and Healing Center (GLYHC), and its staff, teachers, and healers from liability, indemnity, and I agree not to take legal action against the same for healing services and classes I have chosen freely.

_____ _____

Signature Date

_____

Print Name

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Print Name