Lotus Center of Oriental Medicine

911 Irwin Street, Ste A San Rafael California 94901
Phone 415.459.2245 ~ Fax 415.459.8938
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_____

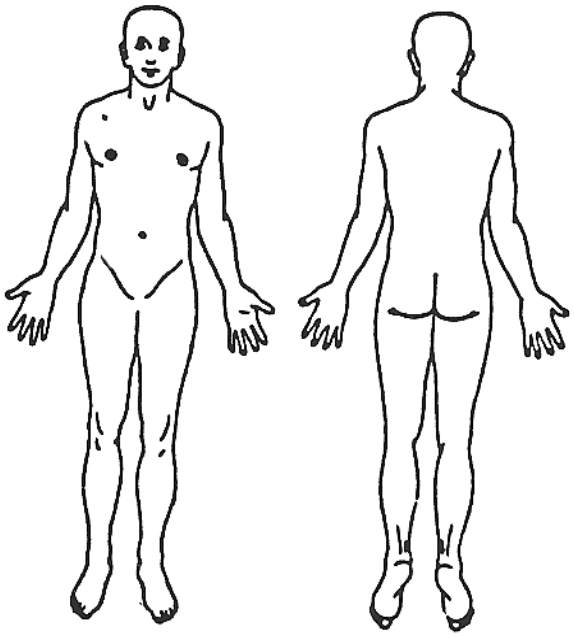
DESCRIPTION OF COMPLAINT

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

LIST MEDICATIONS

OTHER COMMENTS

Name_____ Date_____

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

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

EYES & EARS

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

NOSE & THROAT

- O Nose bleeds
- O Nasal obstruction
- O Nasal drainage
- O Loss of smell
- O Sinus infection
- O Hay fever
- O Allergies
- O Sore throat / hoarseness
- O Pain near stomach
- O Difficult speech
- O Difficult swallowing
- O Loss of taste
- O Change in taste
- O Dental decay
- O Gum problems
- O Tonsillitis
- O Asthma
- O Frequent colds
- O Enlarged thyroid
- O Enlarged glands

SKIN

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

RESPIRATORY

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

CARDIOVASCULAR

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

MUSCLES AND JOINTS

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

GENITOURINARY

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

GASTROINTESTINAL

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

O Distended abdomen

O Constipation
O Diarrhea
O Black stool
O Blood in stool
O Colon trouble
O Hemorrhoids
O Intestinal worms
O Liver trouble
O Gall bladder trouble
O Jaundice
O Colitis
O Weight trouble

FEMALE

O Excessive flows
O Hot flashes/night sweats
O Irregular cycle
O Cramps of back ache
O Previous miscarriage
O Vaginal discharge
O Vaginal pain
O Congested breast
O Breast pain
O Lumps in breast
O Menopausal symptoms
O Last period

O Reduced sexual energy

O Pregnancy
O Pregnancy complications

MALE

O Genital pain
O Reduced sexual energy
O Premature ejaculation
O Seminal emission
O Impotence
O 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.

_____ Date_____
Signature of Patient or Personal Representative

_____Date_____
Description or Personal Representative's Authority

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.
911 Irwin Street, Ste A
San Rafael California 94901

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

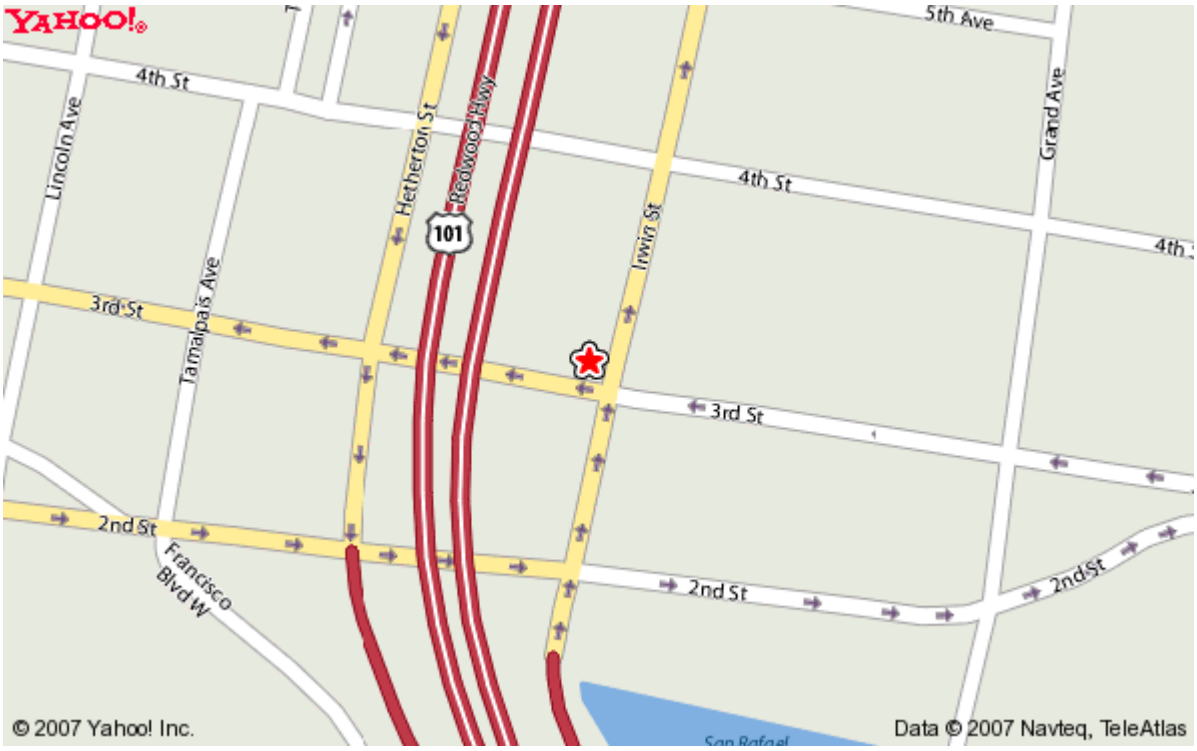
Patient Signature_____Date_____

PARKING INFORMATION FOR NEW CLIENTS:

There is parking behind our complex directly underneath the 101 freeway. The entrance is from 4th 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 4th 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