URBAN LOTUS
acupuncture + herbs

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1516 Fort Street, Victoria, British Columbia V8S 5J2

Confidential Health History Form

Personal Information

NAME: _____ EMAIL: _____

ADDRESS: _____

PHONE: (home) _____ (work) _____ (cell) _____

DATE OF BIRTH: _____ OCCUPATION: _____

Physician Information

NAME: _____

PHONE: _____

Emergency Contact

NAME: _____

PHONE: _____

How did you hear about Urban Lotus?

REFERRAL ☐ Whom? _____ INTERNET ☐ OTHER ADVERTISING ☐ WALK-IN ☐

Health Concerns

Please list your main reasons for seeking treatment at our clinic.

_____

_____

_____

_____ (more space at end of form)

Health Conditions

Please indicate with a P (past) C (current) or F (family) if any of the conditions below apply.

___ Addictions
___ Allergies
___ Anemia
___ Arrhythmias
___ Arthritis
___ Auto-immune condition
___ Bleeding disorder
___ Cancer
___ Cataracts
___ Chronic fatigue
___ Chronic pain
___ Clotting disorder (i.e., DVT)
___ Diabetes
___ Digestive/intestinal disorder
___ Dizziness/fainting
___ Eating disorder
___ Epilepsy
___ Gallbladder problem
___ Glaucoma
___ Gout
___ Head/spinal cord injury
___ Heart disease
___ Herpes
___ High blood pressure
___ High cholesterol
___ HIV/AIDS
___ Kidney disease
___ Liver disease/hepatitis/cirrhosis
___ Lung condition (i.e., asthma/bronchitis/COPD)
___ Menstrual disorder
___ Migraines/headaches
___ Mononucleosis
___ Multiple sclerosis
___ Osteoporosis
___ Prostate condition
___ Psychiatric condition
___ Skin condition (i.e., eczema, rosacea)
___ Sprain/strain/fracture/broken bone
___ Stroke
___ Thyroid disorder
___ TMJ disorder
___ Tuberculosis
___ Venereal disease

Other: _____

Other: _____

Current Symptoms

For each symptom below that you currently have, please rate it's severity on a scale of 1–5 (5 being worst). Leave blank if you do not experience this symptom.

LIVER (WOOD)
___ Irritability/frustration/impatience
___ Depression
___ Stress
___ Emotional eating
___ Unfulfilled desires
___ Visual problems/floaters
___ Blurred vision/poor night vision
___ Red/dry/itchy eyes
___ Headaches/migraines
___ Dizziness
___ Feeling of lump in throat
___ Muscle twitching/spasm
___ Neck/shoulder tension
___ Brittle nails
___ Sighing
___ Sensation or pain under rib cage
___ Premenstrual Syndrome (PMS)
___ Genital itching/pain/rashes

HEART (FIRE)
___ Palpitations
___ Chest pain/tightness
___ Insomnia/sleep problems
___ Restless/easily agitated
___ Anxious
___ Vivid dreams
___ Lack of joy in life
___ Forgetful
___ Aversion to heat
___ Bitter taste in mouth
___ Tongue/mouth ulcers or cankers

KIDNEY (WATER)
___ Frequent urination
___ Bladder infection
___ Lack of bladder control
___ Wake to urinate
___ Feel cold easily
___ Cold hands/feet
___ Night sweats/hot flushing
___ Low sex drive
___ High sex drive
___ Loss of head hair
___ Hearing problems
___ Crave salty food
___ Fear
___ Poor long term memory
___ Ankle swelling
___ Tinnitus
___ Impotency

LUNG (METAL)
___ Dry cough
___ Cough with phlegm
___ Nasal discharge/drip
___ Sinus congestion/infection
___ Itchy/painful throat
___ Dry mouth/throat/nose
___ Skin rashes/hives
___ Snoring
___ Grief/sadness
___ Shortness of breath
___ Allergies/asthma
___ Weak immune system
___ Alternating fever/chills

SPLEEN (EARTH)
___ Heaviness in the head/body
___ Fatigue after eating
___ Difficult getting up in morning
___ Water retention
___ Muscular tiredness/weakness
___ Bruise easily
___ Unusual bleeding (i.e., stool, nose, etc)
___ Bad breath
___ Poor appetite
___ Increased appetite
___ Crave sweets
___ Poor digestion
___ Nausea/vomiting
___ Bloating/gas
___ Hemorrhoids
___ Constipation
___ Loose stools
___ Alternating constipation/loose stools
___ Abdominal pain
___ Intestinal pain/cramping
___ Heartburn
___ Pensive/over-thinking
___ Overweight
___ Foggy mind
___ Yeast infection
___ Aversion to cold
___ Cold nose
___ Increased thirst
___ Sweat easily

General Health

ENERGY: On a scale of 1–10, how would you rate your daily energy level (10 being best)? ___

DIET: Please describe in general what you eat and what you crave. _____

_____

EXERCISE: Do you follow an exercise routine (Y/N)? ___ If so, what type of exercise and how often? _____

_____

HEALTH HABITS: Please indicate how often you use any of the following.

Caffeine: ___ cups/day Tobacco: ___ /day Alcohol: ___ glasses/week Recreational drugs: ___ /day Sugar: ___ tsp/day

MEDICATIONS: Please list any medications you are currently taking. _____

_____

VITAMINS/SUPPLEMENTS: Please list any vitamins/supplements you are currently taking. _____

_____

ALLERGIES: Please list any medication, food or environmental substances that you are allergic to and the reaction you have.

_____

SURGERIES/HOSPITALIZATIONS: Please list all previous surgeries and hospital stays. _____

_____

PAIN: Please answer the following questions as they describe each pain you experience. (more space at end of form)

Location(s)? _____

Severity of each (on a scale of 1–10, 10 being worst)? _____

Quality? (i.e., sharp, dull, achiness, heavy, burning, tingling, stabbing, shooting, throbbing, numb, moving) _____

_____

What relieves the pain? _____

What aggravates the pain? _____

Women's Health

MENSTRUAL HISTORY: How old were you when you began menstruating? ___ Is your cycle regular (Y/N)? ___

How many days are your current cycles? (i.e., 26–30 days) ___ How many days do you bleed in total? ___

How heavy is your flow? Light ☐ Heavy ☐ Average ☐ What is the consistency? Watery ☐ Thick ☐ Average ☐

What is the colour? Pale ☐ Red ☐ Dark red ☐ Purple ☐ Brown ☐ Does your blood contain clots (Y/N)? ___

Do you experience menstrual pain (Y/N)? ___ When? Before menses ☐ During menses ☐ After menses ☐

Quality? (i.e., stabbing/cramping/dull/heavy) _____

What relieves the pain? _____

Do you experience premenstrual symptoms (Y/N)? ___ Please describe: (i.e., breast tenderness, moodiness, fatigue, bloating, change in bowel pattern, headaches, nausea, acne, night sweats, sleep disturbances, cravings, pain)

_____

Are you: Perimenopausal ☐ Postmenopausal ☐ Age of onset: ___ Describe any past or current symptoms: _____

_____

_____

_____

FERTILITY: Are you currently using any form of contraception (Y/N)? ___ What kind? (i.e., condoms, IUD, oral contraception)

For how long? _____

Have you ever been pregnant (Y/N)? ___ How many times? ___ Have you ever given birth (Y/N)? ___ How many times? ___

Are you currently pregnant (Y/N)? ___ Are you currently trying to become pregnant (Y/N)? ___

Did you have any concerns during your pregnancies or deliveries? Please describe. _____

Have you ever had a miscarriage (Y/N)? ___ How many times? ___ At how many weeks of pregnancy? ___

GENERAL GYNECOLOGY: Have you ever been diagnosed with any of the following?

Polycystic ovarian syndrome (PCOS) ☐ Endometriosis ☐ STD ☐ Pelvic Inflammatory Disease ☐ Uterine fibroids ☐ Polyps ☐

Prolapsed uterus ☐ Unique shape of the uterus ☐ Abnormal Pap smear ☐ Repeated yeast infection ☐ Breast lump ☐

Do you experience vaginal discharge (Y/N)? ___ Colour: White ☐ Yellow ☐ Green ☐ Pink ☐ Red ☐ Brown ☐

Consistency? Watery ☐ Thin ☐ Thick ☐ Sticky ☐ Foul odour (Y/N)? ___

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