



Welcome to Lotus Center

During your first visit, I hope to discuss your health concerns, answer any questions you may have about our services and give you an examination using the Oriental Medical approach. After your examination I will review the results.

If I feel Oriental Medicine may be helpful for you, we can then look at the various options available for treatment for your condition.

It is important that you are on time for all appointments. A certain amount of time is allotted for each patient visit. If you are late, your remaining time may not be sufficient for your full treatment. Also, if in the future you need to cancel or reschedule an appointment, please do so (by phone, not email) as soon as possible. **Appointments not canceled 24 hours in advance of the scheduled appointment time will be charged a missed appointment fee.**

I agree to the *Lotus Center* No Show Policy (please initial and date): _____

PLEASE PRINT

Patient Name _____ Date of Birth _____

Street _____ City _____ State/Zip _____

Phone (home) _____ (work) _____ (cell) _____

Email _____ Age _____ Weight _____ Height _____

Occupation _____

Spouse/Partner _____ In Emergency Notify _____

Referred by _____ Family Physician _____

Please List the Main Health Problems You Would Like to be Free of in Order of Importance:

1.) _____

2.) _____

3.) _____

Overall, how would you rate you health: Excellent _____ Good _____ Fair _____ Poor _____

PAST MEDICAL HISTORY (YOURS, WITH APPROXIMATE DATES)

- Allergies _____
- Seizures _____
- Cancer _____
- Stroke _____
- Problems at birth _____
- Childhood Illnesses _____
- Other significant illnesses _____
- Pace maker _____
- Diabetes _____
- Alcoholism _____
- Ulcers _____
- High blood pressure _____
- Chronic illnesses _____
- Hepatitis _____
- AIDS/HIV _____
- Sexually transmitted disease _____
- Accidents / significant trauma _____
- Surgeries _____

LIFESTYLE AND OCCUPATION

Exercise: _____

Dietary considerations:

Use/Amount: Tobacco _____ Coffee/Tea/Soda _____ Alcohol _____ Other _____

Current medications, herbs, supplements: _____

Occupational stress factors: _____

CURRENT GENERAL HEALTH PROBLEMS

- Poor or heavy appetite
- Disturbing dreams
- Difficulty sleeping
- Difficulty staying awake/alert
- Fatigue
- Bleeding or bruising easily
- Headache
- Sinus pressure/pain
- Strong thirst
- Cravings
- Weight loss or gain
- Tremors
- Feet : Cold Hot
- Hands : Cold Hot
- Night sweats
- Fevers, heat sensations
- Chills
- Sweat too easily

SKIN AND HAIR

Do you have problems with skin or hair? Describe: _____

Problems with eyes, ears, nose or throat? Describe: _____

- Catch colds easily
- Sores in or around mouth

HEART AND RESPIRATION

- Heart palpitations
- Chest pain
- Irregular heartbeat
- Fainting
- Swelling of hands or feet
- Blood clots
- Cough
- Production of phlegm
- Shortness of breath or labored breathing
- Chest constriction

DIGESTION AND ELIMINATION

- Problems with digestion
- Problems with elimination (bowel movement)
- Gas and bloating
- Acid Reflux
- Chronic laxative use
- Mucus in stools

GENITO-URINARY

- Problems with urination
- Difficulty holding urine
- Waking at night to urinate
- Problems in genital area
- Problems with sexuality
- Libido is: high low
- Color of urine is: dark straw colored clear

MIND AND NERVOUS SYSTEM

- Seizures or Tics
- Loss of balance
- Poor memory
- Mental fogginess
- Ongoing or overwhelming feelings of (circle any that apply): irritability worry fear sadness grief anger frustration guilt shame
- Seeing a psychotherapist or counselor
- Considered or attempted suicide
- Any other comments/concerns _____

FOR WOMEN ONLY

- Are you pregnant now? _____
- Age at menarche _____
- Age at menopause _____
- Number of pregnancies _____
- Number of live births _____
- Premature births
- Miscarriages/abortions
- Menstrual clots
- Painful menses
- Irregular menses
- Length of cycle: (first day of one to first day of next) _____
- Duration of flow _____
- Premenstrual changes
- Strong menstrual odor
- Vaginal discharge
- Vaginal odor
- Breast lumps or swellings
- Birth control method (with dates) _____
- Other concerns _____

I consent to the treatment of acupuncture, moxibustion, electro-acupuncture, and other forms of traditional Chinese Medicine as deemed necessary by Michele Salinas, LAc, Dipl OM and governed by North Carolina law including the recommendation of herbs and foods in the pursuit of health care. I agree that once I purchase custom blended herbal formulas they are neither returnable nor refundable. I understand that opened bottles of prepared herbs and special orders also are not refundable. No medical information concerning my health care will be shared by *Lotus Center* without my consent.

Signature _____

If you are experiencing pain, shade those areas

