

Lotus Acupuncture & Fertility Clinic

Zhenbo Li, LAc

513 N Morrison Rd, Vancouver, WA 98664

(360) 984-6489

Name: _____ Today's Date: _____
(First) (Middle) (Last) (MM/DD/YY)

DOB: _____ Gender: ___ Pronoun: _____ Height: _____ Weight: _____ Occupation: _____

Home Address: _____
(Street Number) (City) (State) (Zip Code)

Home Phone: _____ Cell Phone: _____ E-mail: _____

Emergency Contact: _____ Telephone: _____ Relationship: _____

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. Please identify the health concerns that have brought you to the clinic (condition, onset, severity, treatment):

Chief Complaint: _____

Secondary and other
Complaints: _____

2. What are your most important health problems? Please list in order of importance.

a. _____ b. _____

c. _____ d. _____

3. Please list any prescription medications and over-the-counter medications that you are currently taking (also indicate the purpose for medications):

1. _____ 2. _____

3. _____ 4. _____

4. Please list any foods, drugs, or medications you are hypersensitive or allergic to (also include the type of reaction)

5. Are you currently receiving health care? Y N

If yes, where and from whom?

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Patient Name:

DOB:

Visit Date:

6. X-Rays/CAT Scans/MRI's/NMR's/Special Studies (Reason, When, Result):

7. Hospitalizations and Surgeries (Reason, Where, When):

8. Do you have any reason to believe that you are pregnant? Y N

9. Do you have any chronic infectious diseases? Y N If yes, please explain: _____

10. Are you currently suffering from any chronic illness? Y N If yes, please explain: _____

11. Family History of Diseases (please indicate paternal or maternal)

12: Do you generally feel warm _____, or cold _____ ?

13. Do you have perspiration daytime _____, night _____ ?

14. Describe your energy condition _____

15. Describe your bowel movement, frequency, loose or constipation

16. Describe your urination condition _____

17. Describe your mental/emotional condition _____

18: Describe your sleep condition _____

19. Smoking: Yes __, No __ If yes, how much? _____

Alcohol: Yes __, No __ If yes, how much? _____

Coffee: Yes __, No __ If yes, how much? _____

Drugs: Yes __, No __ If yes, how much? Which drug _____

20. Describe your diet _____

21. Describe your exercises _____

22. Is there anything else we should know? _____