Sheridan Richardson, L.Ac ~ Lotus Acupuncture & Healing Arts ~ 827 Bayside Rd Arcata CA 95521 ~ 707 633-4005

PATIENT INFORMATION

Patient's Name: _____**Date**: _____

Address: _____ **Zip Code:** _____

Home Phone:_____ **Cell/Work Phone:**_____

Date of Birth: _____**Gender:** _____

Emergency Contact: _____**Relationship**_____

Email address: _____

Would you like to receive our newsletter Y N

Please Answer Questionnaire As Completely as Possible:

1.) Are you currently receiving healthcare? Y N If yes, from whom?

_____

_____

If no, when was the last time you did receive health care?

_____

Please identify the chief reasons for your visit below:

1.)_____Onset:_____

How does this condition affect you?_____

Past treatment: _____

2.) _____ Onset:_____

How does this condition affect you? _____

Past treatment: _____

3.) _____ Onset: _____

Do you have any reason to believe that you are pregnant? _____

Are you currently suffering from any chronic illness? _____

Please list any prescription medications, over-the-counter medications, vitamins, and supplements that you are currently taking:

_____

_____

If applicable, please list any foods, drugs, or medications that you are hypersensitive or allergic to and please include the type of reaction:

_____

_____

Hospitalizations and surgeries:

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

Family History:	Mother	Father	Brothers	Sisters	Spouse	Children
Age:	_____	_____	_____	_____	_____	_____
Health (G:good;P:poor):	_____	_____	_____	_____	_____	_____
Age at Death:	_____	_____	_____	_____	_____	_____
Cause of Death:	_____	_____	_____	_____	_____	_____

Check any conditions that family members have had:

Cancer:	_____	_____	_____	_____	_____	_____
Diabetes:	_____	_____	_____	_____	_____	_____
Heart Disease:	_____	_____	_____	_____	_____	_____
High Blood Pressure:	_____	_____	_____	_____	_____	_____
Stroke:	_____	_____	_____	_____	_____	_____
Mental Illness:	_____	_____	_____	_____	_____	_____

Please Circle any conditions that you currently experience and Underline any that you have had in the past:

Emotional:

Mood Swings Nervousness Mental Tension Irritability Uncontrollable Sadness

Energy and Immunity:

Fatigue Slow Wound Healing Chronic infections Chronic Fatigue Syndrome

Head, Eye, Ear, Nose and Throat:

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Hay fever

Respiratory:

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema Pleurisy

Persistent Cough Asthma Tuberculosis Shortness of Breath Other

Cardiovascular:

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure Palpitations

Stroke Heart Murmurs Rheumatic Fever Varicose Veins

Gastrointestinal:

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids

Abdominal Pain **Stool:** Diarrhea Constipation Undigested Food Mucous Blood in Stool

Genito-Urinary Tract:

Kidney disease Painful Urination Frequent Urinary Tract Infections Frequent urination

Venereal disease Kidney stones Impaired Urination Blood in Urine

Female Reproductive/Breasts:

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow Clotting

Bleeding Between Cycles Vaginal Discharge PMS Peri-menopausal issues

Difficulty Conceiving Infertility

Menstrual/Birthing History:

Age of 1st Menses: _____ Length of Cycle: _____ # of Days of Menses: _____

Birth Control: _____ # of Pregnancies: _____ # of Live Births: _____

# of Miscarriages: _____ # of Abortions: _____

Male Reproductive:

Sexual Difficulties Prostate Issues Testicular pain/Swelling Penile Discharge

Musculoskeletal:

Neck/Shoulder Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Neurologic:

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

Endocrine:

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats

Cold Sweats Feeling Hot or Cold

Other:

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Do you have any chronic infections? _____

Is there anything else you would like me to know? _____

Lifestyle

Please indicate typical food intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Daily Exercise: _____

Sleep Habits: _____

Education: _____

Occupation: _____ Hours/Week: _____

Do you enjoy work? Y N Why?/Why Not? _____

Nicotine/Alcohol/Caffeine Use: _____

Have you experienced any major traumas? Y N Please explain: _____

_____

Consumption of liquids: _____

Television habits: _____

Interests and Hobbies:_____