Lotus Wellspring Healthcare
Dr. Sybil Ihrig, DACM, L.Ac., CCH

Personal Information

Name:_____ Age:_____ Birth Date:_____

Address, City, State, Zip Code:_____

Primary Phone number:_____Alternate:_____

E-mail address:_____

If under 18, person responsible for your account:_____

Gender: □ Male □ Female Height:_____ Weight:_____ Ideal Weight:_____

Occupation: _____

Relationship status: □ Single □ Partnered □ Married □ Divorced □ Separated □ Widowed

Emergency Contact Name:_____ Contact Phone:_____

Primary Care Physician:_____ Phone:_____

May we contact him/her? □ Yes □ No How did you hear about us? _____

Have you had acupuncture therapy before? □ Yes □ No Are you a veteran? □ Yes □ No

Please indicate if any of the following pertain to you:

☐ Hepatitis ☐ HIV ☐ High Blood Pressure ☐ Seizures ☐ Pacemaker ☐ Blood-thinning medication

Please indicate how frequently you consume the following:

Coffee:_____ Soda:_____ Water:_____

Alcohol:_____ Tobacco:_____ Other drugs: _____

Please list any prescription or over-the-counter medications and supplements you are presently taking and the reason for taking them:

Medication	Dosage	Reason	Medication	Dosage	Reason

What would you like to accomplish with East Asian medicine? This is NOT your chief complaint but rather your health goal (i.e. to run a 5k without pain, to fly on a plane without dizziness, to have the energy to keep up with your nephew, etc.)

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Health History

Please indicate the **top 3** health concerns for which you are seeking treatment and how long you have been experiencing them:

1. _____

2._____

3._____

What other forms of treatment have you sought?

_____

Does anything make your condition better or worse?

_____

Please list any surgeries or major health incidents (accidents, etc.) in your life and date(s) of occurrence:

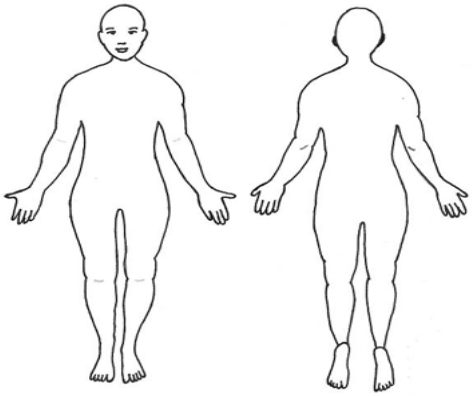
_____

_____

_____

_____

If you experience any physical pain, please indicate where and since when:



How would you characterize your physical pain?

☐ dull/achy ☐ sharp/stabbing ☐ burning ☐ tingling /numbness ☐ electrical ☐ throbbing ☐☐stiff

☐ tight ☐ continuous ☐ comes and goes ☐ fixed location ☐ moves around ☐ shooting/radiating

How would you rank your pain on a scale of 1-10, 10 meaning "I need to go to the Emergency Room."

Day to day: _____ At its lowest: _____ At its highest: _____

Family History

Do you have a family history of any of the following diseases or conditions? When answering, include your parents, brother/sisters, and grandparents, if known. Check all that apply.

☐ Anemia ☐ Cancer ☐ Heart Disease ☐ Mental Illness ☐ Alzheimer's ☐ Arthritis ☐ Diabetes ☐ Hypertension

☐ Multiple Sclerosis ☐ Stroke ☐Asthma ☐ Epilepsy ☐ Kidney Disease ☐ Parkinson's ☐ Other (list below)

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Symptoms Survey

Please indicate the symptoms or conditions you currently experience:

SP/ST Earth

- ☐ Excessive appetite
- ☐ Lack of appetite
- ☐ Low energy after a meal
- ☐ Gas or bloating
- ☐ Acid reflux/Heartburn
- ☐ Ulcers / Gastritis
- ☐ Fatigue
- ☐ Loss of muscle strength
- ☐ Hemorrhoids
- ☐ Organ prolapses (where)?
- ☐ Worried thoughts
- ☐ Obsessions or compulsions

LV/GB Wood

- ☐ Vision issues/changes
- ☐ Jaundice
- ☐ Loud, low ringing in ears
- ☐ Belching
- ☐ Irritability
- ☐ Depression
- ☐ Brittle hair or nails
- ☐ Discomfort around rib cage
- ☐ Gallstones
- ☐ Headaches (temporal)
- ☐ Indecision
- ☐ Muscle spasms

KI/UB Water

- ☐ High/quiet ringing in ears
- ☐ Diminished hearing
- ☐ Dry mouth
- ☐ High or low libido (circle)
- ☐ Night sweats or hot flashes
- ☐ Spinal or bone problems
- ☐ Kidney/bladder stones
- ☐ Edema/swelling
- ☐ Urinary problems
- ☐ Weakness in knees/legs
- ☐ Lack of will power
- ☐ Anxiety / fearfulness

HT/SI Fire

- ☐ Difficulty focusing
- ☐ Forgetfulness
- ☐ Nightmares / Vivid dreams
- ☐ Insomnia
- ☐ Mental restlessness
- ☐ Easy excitability
- ☐ Chest pain
- ☐ Palpitations/afibrillation
- ☐ Mouth or tongue ulcers

PC/SJ Minister Fire

- ☐ PTSD
- ☐ Abuse sufferer
- ☐ Repetitive emotional trauma
- ☐ Immune system disorders
- ☐ Lymphatic problems
- ☐ Endocrine disorders
- ☐ Joylessness

LU/LI Metal

- ☐ Cough
- ☐ Shortness of breath
- ☐ Nasal/chest congestion
- ☐ Allergies
- ☐ Asthma /bronchitis/COPD
- ☐ Spontaneous sweating
- ☐ Skin issues
- ☐ Constipation
- ☐ Diarrhea or loose stools

I usually feel: ☐ Hot ☐ Cold Are any parts of your body hotter or colder than others?

Lifestyle

How many hours of sleep do you get each night? _____

Do you experience: ☐ Difficulty falling asleep ☐ Staying asleep ☐ Vivid dreams ☐ Wake up not rested

☐ Interrupted sleep: When and why do you wake up? _____

How would you rate your energy level on a scale of 1-10, with 10 being the highest:_____

How would you rate your stress level on a scale of 1-10, with 10 being the highest:_____

Please list your primary sources of stress: _____

How many hours do you work per week? _____ Do you like your work? _____

For Men

Date of your last prostate exam:_____ Are you currently sexually active? ☐ Yes ☐ No

Please explain any concerns you may have with your sexual function or libido:

_____

Please list any STDs you have/have had: _____

How many times do you get up to urinate at night? _____

For Women

Age at first period:_____ Date of last period:_____ Number of days between periods:_____

Number of pregnancies:_____ Miscarriages:_____ Abortions:_____

Are you currently sexually active? ☐ Yes ☐ No Hysterectomy? Year: _____ ☐ Total ☐ Partial

Number of days of flow:_____ Color of blood:_____

Please indicate if you experience the any of these symptoms before or during your menses:

☐ Lower back pain ☐ Diarrhea ☐ Constipation ☐ Moods/Weepy ☐ Breast pain/soreness ☐ Blood clots

☐ Increased appetite ☐ Decreased appetite ☐ Headache ☐ Nausea ☐ Insomnia ☐ Fatigue

☐ Hemorrhoids ☐ Bloating ☐ Down-bearing sensation ☐ Scant or late menses ☐ Irregular menses

Please indicate if you experience any of these other gynecological symptoms:

☐ Vaginal dryness ☐ Profuse vaginal discharge ☐ Yeast infections ☐ Urinary tract infections

Please indicate if you have been diagnosed with any of the following:

☐ Fibroids ☐ Fibrocystic breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ Polycystic Ovary Syndrome

☐ Pelvic Inflammatory Disorder

Please list any STDs you have/have had: _____

Is there any chance you might be pregnant now? _____

Did we miss anything? Anything else you'd like us to know?