#### BLUE LOTUS HEALTH and WELLNESS

#### Lowell M. Chodosh ND, LAc

####  REGISTRATION FORM

Name: ­­­­

Address:

City: Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

Phone (Home): (Work): (Cell):

E-mail:

Male ❒ Female ❒ Date of Birth:

Occupation: Employed By:

Marital Status: Number of children:

What contact number do you prefer I use? \_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message? \_\_\_\_\_\_

Emergency Contact: Phone: Relation:

Name of Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

How did you hear about me? Friends ❒ Family ❒ Presentation ❒ Website ❒ Newspaper ❒ Other:

This is a confidential record of your medical history. Information contained in it will not be released to any person unless authorized by you.

#### Health Concerns

What are your main health concerns? (MORE SPACE ON LAST PAGE.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vitamins and Supplements**

Please list all vitamin/mineral/herbal or other supplements you are currently taking:

|  |  |  |
| --- | --- | --- |
| Supplement (Including Brand) | Dosage | When did you begin the supplement and why? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

#### Medications

Please list all prescription and non-prescription medications you are currently taking:

|  |  |  |
| --- | --- | --- |
| Medication | Dosage | When did you begin this medication and why? |
|  |  |  |
|  |  |  |

Please list any major illnesses, surgeries or diagnosed diseases that you have or have had:

 \_\_\_\_\_\_

 \_\_\_\_\_\_

 \_\_\_\_\_\_

 \_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BELOW, PLEASE CIRCLE IF CURRENT AND/OR CHECK IF IN THE PAST**

|  |
| --- |
| General |

* Severe weakness
* Tiredness/fatigue
* Change in appetite
* Change in thirst
* Addictions
* Weight gain
* Weight loss
* Poor sleep
* Chills or fever
* Night sweats
* Allergies
* Tumor/Cancer
* Diabetes
* Headaches
* Artificial joint
* Pain
* Numbness
* Arm/leg numbness
* Arm/leg tingling
* Swellings
* Thyroid problems
* Reproductive problems
* Broken bones
* Bone or joint problems
* Back pain or injury
* Dizziness/fainting
* Epilepsy/seizures
* Emotional problems
* Psychiatric problems
* Eating disorder
* Bleeding or blood disorder/Anemia
* Immune problems
* Hearing loss or ear problems
* Skin problems or chronic rash
* Eye problems
* Lung problems
* Any other illness not listed (the last page has space to write)

|  |
| --- |
| Cardiovascular |

* Chest pain
* Palpitations
* High blood pressure
* Low blood pressure
* Pacemaker
* Artificial heart valve
* Easy Bruising
* Heart trouble/Attack
* Irregular Heart Beat
* Murmurs
* Other

|  |
| --- |
| Gastrointestinal |

* Vomiting blood
* Nausea/Vomiting
* Tumor/Cancer
* Stomach or Intestinal Pain
* Gas/Flatulence
* Ulcers
* Heartburn/Reflux
* No Appetite
* Blood in stool
* Liver problems
* Stomach problems
* Intestinal problems
* Food sensitivities
* Digestive problems
* Other

|  |
| --- |
| **Respiratory** |

* Shortness of breath
* Asthma
* Difficulty breathing
* Chronic coughing
* Blockage of Nose
* Unable to Smell
* Throat problems
* Wheezing
* Other

|  |
| --- |
| **Sleep** |

* Wake often
* Restless
* Insomnia
* Difficulty falling asleep
* Take naps
* Take sleep meds
* Use recreational drugs or alcohol before sleep
* Poor sleep habits
* Sleep Apnea
* Use CPAP

|  |
| --- |
| Neurological |

* Anxiety
* Depression
* Paralysis
* Stroke
* Memory problems
* Suicidal
* Other

**Infections**

* Hepatitis
* HIV/AIDS
* Chronic or recurrent infections
* Parasitic infections
* Other

|  |
| --- |
| Urinary |

* Pain on urination
* Blood in urine
* Kidney stones
* Kidney disease
* Difficult urination

|  |
| --- |
| **Anal/Rectal/Colon** |

* Tumor/Cancer
* Polyps
* Warts
* Difficult Bowel Mvts
* Constipation
* Diarrhea
* Loose stools
* Other

|  |
| --- |
| **Male Reproductive** |

* Sexually transmitted diseases
* Sores on genitals
* Discharge
* Testicular Mass
* Testicular pain
* Hernia
* Herpes
* Other

|  |
| --- |
| **Female Reproductive** |

* Irregular periods
* Heavy
* Light
* Clots
* Painful periods
* PMS
* Sore breasts with menses
* Infertility
* Sexually transmitted diseases
* Vaginal sores
* Vaginal discharge
* Herpes
* Other

Date of last Pap \_\_\_\_\_\_

*Menopausal* Y N

Age of last menses \_\_\_\_\_

*Age of first menses \_\_\_\_*

*LAST GYN exam \_\_\_\_\_\_*

*Pregnant* Y N

Do you practice birth control?

Y N Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Breasts** |

* Lumps
* Tender
* Nipple discharge
* Pain
* Other

Do you do breast self-exams? Y N

**MISC.**

How frequently do you move your bowels?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours of sleep do you get on average? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you rested after sleep Y N

How many hours do you work each day?

Do you often feel stressed? Y N

Do you exercise? Y N

If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_

What kind?

**Diet**: Non Vegetarian ❒ Vegetarian ❒

Vegan ❒ how long?\_\_\_

**VACCINATIONS: Please check all that apply**

|  |  |
| --- | --- |
| MMRcombo measles mumps rubella |  |
| dTAPcombo dipht, tetanus, pertussis |  |
| Measles |  |
| Mumps |  |
| Chicken Pox (Varicella) |  |
| German measles (Rubella) |  |
| Smallpox (Vaccinia) |  |
| Diptheria |  |
| Tetanus |  |
| Pertussis (Whooping Cough) |  |
| HPV (Human Papilloma Virus) |  |
| Haemophilus influenza |  |
| Hepatitis A |  |
| Hepatitis B |  |
| Rotavirus |  |
| Polio |  |
| Pneumococcal (Pneumonia) |  |
| Meningococcal (Meningitis) |  |
| Influenza |  |
| Travel Vaccines (which?) |  |
|  |  |
| Other: |  |

#### FAMILY HISTORY

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Mother | Father | Sister | Brother | Grandparents | Relative |
| Cancer |  |  |  |  |  |  |
| Heart disease |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |  |
| Alzheimer’s/Dementia |  |  |  |  |  |  |
| Parkinson’s |  |  |  |  |  |  |
| Disabilities |  |  |  |  |  |  |
| Addictions eg Alcohol, Cannabis, drugs, etc |  |  |  |  |  |  |
| Medications |  |  |  |  |  |  |

#### Personal Habits and Lifestyle

How many cups/bottles/glasses do you drink, on average, per day?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Coffee |  | Milk |  | Fruit Juice |  |
| Water |  | Smoothies |  | Vegetable Juice |  |
| Herbal Tea |  | Beer |  | Soft Drinks (regular) |  |
| Black Tea |  | Wine |  | Soft Drinks (diet) |  |
| Green Tea |  | Liquor |  | Other |  |

Please check “✓” the source of your drinking water.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Tap (city)...... |  | Well........ |   | Bottled (spring)... |   | Filtered.... |  | Distilled.  |  |

Do you use a cell phone? What model?

How do you use it:

Is it on Airplane mode next to bed when you sleep?

On your arm or person when at the gym?

Use iPod Bluetooth ear device?

Hold your phone when you search/text/read/watch videos?

Do you have smart meters in your home?

Wifi in your home? Do you turn it off at night? Do you use a wifi signal booster?

Wifi or cell tower nearby?

Cigarette smoking or vaping: Please check appropriate space

\_\_\_\_\_\_Currently \_\_\_\_\_\_ In the past \_\_\_\_\_\_\_Never

If you smoke or have smoked in the past, please fill in the following information:

Years smoking: Type of smoking: Quantity per day:

Do you use marijuana or other recreational drugs? Y N

Which ones and how often:

PLEASE NOTE: **I request that you not use Marijuana, Alcohol, Recreational Drugs or Opiates before a massage or acupuncture treatment as it will affect the application and benefit of the therapies used.**

ALCOHOL: \_\_\_\_Currently drink \_\_\_\_Drank in past \_\_\_\_\_Never drank

Was or is drinking a problem for you or for others? Y N

If you drink alcohol, how often?

Could you be at risk for sexually transmitted diseases? Y N

Risk factors include multiple sexual partners (>25), partners with HIV/AIDS, chlamydia, gonorrhea, syphillis, warts, herpes, hepatitis, a history of intravenous/nasal drug abuse, non-commercial piercings or tattoos.

Ever tested for HIV or Hepatitis? Y N Result?

Have you ever been to a naturopath? Y N Used natural medicine? Y N

Have you ever been to an acupuncturist? Y N Used Chinese herbal medicine? Y N

Have you used or are you presently using homeopathic medicines?

Have you had any lab tests done within the past year?

When and what tests?

Any significant findings on any lab tests presently or in the past?

What were they?

Have you had any diagnostic imaging done (X-rays, MRI, CT scans etc.)

Results?

When was your last physical examination?

Known Food Allergies/Intolerance:

Known Environmental Allergies/Sensitivities:

PLEASE USE THIS SPACE AND THE BACK OF THIS PAGE FOR ANY CONCERNS, QUESTIONS OR OTHER INFORMATION THAT YOU FEEL IS IMPORTANT OR TO ANSWER EARLIER QUESTIONS MORE COMPLETELY.

YOUR HONESTY AND OPENNESS IS APPRECIATED AND NECESSARY IF I AM TO UNDERSTAND HOW I CAN BEST HELP YOU :

3-3-20