



Rising Lotus

Wellness Center

"The Standard in Acupuncture"



132 W. Collins Dr.
Casper, WY 82601 ♦ Phone: 307-577-6333

www.RisingLotus.net ♦ Laird@RisingLotus.net

- Thank you for allowing us the opportunity to serve you.
- If you are currently being treated by other health care practitioners, please inform us. It may be important for us to establish communication with them for your best care.
- We encourage your questions! Please feel free to ask, or write them down and we'll discuss them.
- Due to tight scheduling, if you are late for your appointment, your scheduled time may need to be adjusted accordingly.
- Cancellations require a 24-hour notification. Failure to provide 24 hours notice may require full payment of the session missed unless we are able to fill the appointment time. There is frequently a waiting list for appointments and cancellations with less than 24 hours notice may not allow us enough time to notify someone else.
- If you are ill, please call us prior to your appointment and discuss it with us. Acupuncture can safely be utilized with almost all illnesses. Clients with special considerations (skin allergies/conditions, serious medical conditions, pregnancy, etc.) may contact me prior to their appointment for verification.
- There may be situations (just about never!) that require cancellation of your appointment. I will strive to provide you with as much notice as possible should this occur. A discount for the rescheduled appointment may be applied with less than 24-hours notification.
- Gift Certificates of any amount are available for purchase for friends and family.

We strive to provide a professional and comfortable environment to all of our clients and we therefore appreciate your understanding of our efforts to clarify these points.

Thank You!

Jason Laird, L. Ac.



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Health History Questionnaire

Important: The information on this form will help your acupuncturist to give you the best and most comprehensive care possible. It is important for you to complete this document as thoroughly as possible. Even though some of the questions may seem unrelated to your condition, they may play a contributing, or underlying role in diagnosis and treatment of your problem.

All of the information provided is strictly confidential

General Patient Information

Today's Date ____ / ____ / ____

Name: _____ Age: _____ D.O.B. ____ / ____ / ____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

E-Mail Address _____ Occupation: _____ Employer: _____

Gender: Male Female || **Height:** ____' ____" || **Current weight:** _____ lbs. || **Ideal weight:** _____ lbs.

Marital Status: Single Married Separated Divorced Widowed

Spouse's Name _____ Spouse's Occupation: _____

Name of guardian (if under 18) _____

In case of emergency, whom should we notify? _____ Relationship: _____

Contact Number: _____ Address: _____

How did you hear about our office? _____

Name of your primary health care provider: _____

Name of your Chiropractor: _____

Major Health Complaint(s).

Please list in order of significance to you, along with how long you've had each one:

Major Health Complaints / Symptoms	How Long?	Additional Health Complaints / Symptoms	How Long?
1.		6.	
2.		6.	
3.		7.	
4.		8.	

Do you know what is causing this problem(s)? _____

Smokers

of cigarettes per day _____ How long have you been smoking? _____

If you are a smoker, do you want to quit? Yes No [Level of determination to quit - 1 2 3 4 5 6 7 8 9 10]

Patient Medical History

Please describe your childhood health _____

Have you ever been hospitalized? If so, please describe the procedures you had done, and the dates.

Recent Medical Tests or Procedures (please indicate test results and dates below)

- | | | | |
|------------------------------------|--------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Physical | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Prostate exam | <input type="checkbox"/> Blood test |
| <input type="checkbox"/> HIV / STD | <input type="checkbox"/> Pap smear | <input type="checkbox"/> Mammogram | <input type="checkbox"/> Other |

Test Results and Date: _____

Check any conditions that you have had in the past, or are currently experiencing:

- | | | | |
|---|-------------------------------------|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding or hemorrhage |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Nervous disorder |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Polio | <input type="checkbox"/> Auto Immune Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Fever | <input type="checkbox"/> Migraines, Headaches | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Other | | |

List any surgeries that you've had (Include the year of the surgery): _____

Please list any Prescription, non-prescription or recreational drugs you currently take:

Patient Health Profile

Please check any of the following symptoms that currently pertain to you (if you have symptoms in the following categories, it indicates that you may have a problem with that organ's function)

Overall Body Temperature (*Kidney Organ System*)

- | | | | |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Hot body temperature | <input type="checkbox"/> Profuse perspiration | <input type="checkbox"/> Perspire easily |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold body temperature | <input type="checkbox"/> Lack of perspiration | <input type="checkbox"/> Night time urination |
| <input type="checkbox"/> Sweaty palms | <input type="checkbox"/> Afternoon flushing | <input type="checkbox"/> Night sweating | |
| <input type="checkbox"/> Sweaty feet | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Strong thirst | |

Overall Energy (*Lung and Kidney System*)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Easily fatigued | <input type="checkbox"/> Lethargy | <input type="checkbox"/> Easily prone to illness | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sweating without exertion | <input type="checkbox"/> Frequent colds / flu's / sinuses | <input type="checkbox"/> Chronic allergies |

Blood Function (*Liver, Heart and Spleen System*)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling in extremities | <input type="checkbox"/> Itchy or dry skin | <input type="checkbox"/> Blurry vision |
| <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Scanty menses | <input type="checkbox"/> Weak or brittle nails |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Fainting | |

Heart Function

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Manic moods | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Tongue ulcers |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Restless dreams | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Speech impediment |
| <input type="checkbox"/> Mental restlessness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Depression | <input type="checkbox"/> Severe shyness |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rapid Heart Beating | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Vein condition | | |

Lung Function

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Chronic allergies | <input type="checkbox"/> Dry or flaky skin | |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Nasal dryness | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Sore throats | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Cigarette smoking |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Skin Rashes | <input type="checkbox"/> Skin Ulceration | <input type="checkbox"/> Hives <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Phlegm |
| Allergies to <input type="checkbox"/> Mold <input type="checkbox"/> Cedar <input type="checkbox"/> Pet fur <input type="checkbox"/> Dust <input type="checkbox"/> Pollen <input type="checkbox"/> Oak <input type="checkbox"/> Hay Fever <input type="checkbox"/> Environmentally Sensitive | | | |

Spleen Function

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Low or weak appetite | <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Gurgling in intestines | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abrupt weight gain | <input type="checkbox"/> Gas | <input type="checkbox"/> Fatigue following a meal | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Abrupt weight loss | <input type="checkbox"/> Strong food cravings | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Indigestion |

Stomach Function

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Stomach ache | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Belching | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Ravenous appetite | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hiccups | <input type="checkbox"/> Mouth ulcers |

Accumulated Dampness

- | | | |
|---|---|---|
| <input type="checkbox"/> Mental foginess | <input type="checkbox"/> Swollen hands | <input type="checkbox"/> Edema in the legs |
| <input type="checkbox"/> Mental sluggishness | <input type="checkbox"/> Swollen feet | <input type="checkbox"/> Edema in the abdomen |
| <input type="checkbox"/> Poor mental focus | <input type="checkbox"/> Joint stiffness / ache | <input type="checkbox"/> Chest congestion |
| <input type="checkbox"/> Heaviness of the head, the limbs, or of the whole body | | <input type="checkbox"/> Symptoms worsen in rainy weather |

Bowel Function and Elimination

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Loose stools | <input type="checkbox"/> Constipation | <input type="checkbox"/> Difficulty moving bowels | <input type="checkbox"/> I.B.S. or Colitis |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Small, hard, dry stools | <input type="checkbox"/> Chron's Disease |
| <input type="checkbox"/> Incomplete stools | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Less than 1 BM/ Day | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Black Stools | <input type="checkbox"/> Abdominal Pain | |

Liver and Gall Bladder Function

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Easy to anger | <input type="checkbox"/> Pain in the ribcage | <input type="checkbox"/> Acne |
| <input type="checkbox"/> All over body tension | <input type="checkbox"/> Easily frustrated | <input type="checkbox"/> Heaviness in ribcage | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Chronic neck tension | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Numbness / tingling | <input type="checkbox"/> Shoulder tension | <input type="checkbox"/> Ringing in ears—High Pitch |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Lump in throat | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Eye pain / dryness |
| <input type="checkbox"/> Alternating diarrhea and constipation | <input type="checkbox"/> Easily overwhelmed by stressful circumstances | <input type="checkbox"/> Liver disease | |

Eyes (*Liver Function*)

- | | | | |
|--------------------------------------|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Grittiness | <input type="checkbox"/> Bloodshot | <input type="checkbox"/> Far sighted |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Seeing spots | <input type="checkbox"/> Astigmatism |
| <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Red and irritated | <input type="checkbox"/> Near sighted | <input type="checkbox"/> Glaucoma |

Kidney and Urinary Bladder Function

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Frequent cavities | <input type="checkbox"/> Weak knees | <input type="checkbox"/> Cold lower back | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Broken / loose teeth | <input type="checkbox"/> Knee soreness | <input type="checkbox"/> Cold hips / buttocks | <input type="checkbox"/> Early graying of hair |
| <input type="checkbox"/> Weak bones | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Cold knees | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Quick to fear / fight | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Ringing in ears –Low Pitch |
| <input type="checkbox"/> Kidney disease | | | |

Urinary Function

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Normal color | <input type="checkbox"/> Reddish color | <input type="checkbox"/> Small amount | <input type="checkbox"/> Night-time urination |
| <input type="checkbox"/> Dark Yellow | <input type="checkbox"/> Cloudy | <input type="checkbox"/> Large amount | <input type="checkbox"/> UTI / Pain or burning |
| <input type="checkbox"/> Clear color | <input type="checkbox"/> Strong odor | <input type="checkbox"/> Very frequent | <input type="checkbox"/> Hesitancy |
| <input type="checkbox"/> Difficulty initiating the stream of urination | | <input type="checkbox"/> Dribbling | <input type="checkbox"/> Weak stream |

Libido Function

Male

- | | | |
|--|---|---|
| <input type="checkbox"/> Early ejaculation | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Nocturnal emissions |
| <input type="checkbox"/> Difficulty getting or maintaining an erection | <input type="checkbox"/> Spermatorrhea | <input type="checkbox"/> Discolored or yellow semen |
| <input type="checkbox"/> Pain in the penis or testicles | <input type="checkbox"/> Thick or dense semen | <input type="checkbox"/> Other _____ |

Female

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Frequent Vaginal Infections | <input type="checkbox"/> Pelvic Infection | <input type="checkbox"/> Clots | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Vaginal Dryness | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Irregular Periods | Age of 1 st menses _____ |
| <input type="checkbox"/> Pain or Cramps | <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Birth Control? How Long ____ |
| First Date of Last Period _____ | Duration of flow _____ Days | Cycle _____ Days | |

Both

- Normal High sex drive Diminished sex drive Infertility Fatigue following sexual activity

Musculo-skeletal

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Joint Disorders | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Pain/Soreness in muscles | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Difficult Walking | <input type="checkbox"/> Spinal Curvature | <input type="checkbox"/> Hernia | <input type="checkbox"/> Neck Tightness / Pain |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Hand/Wrist Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Sprain of Joint | <input type="checkbox"/> Poor Coordination | <input type="checkbox"/> Other: _____ |

Appointment Reminders and Health Care Information Authorization

Members of the staff of the Rising Lotus Wellness Center may need to use your name, address, phone number to contact you with appointment reminders, information about your treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering device or with whoever answers the phone. Thank you cards, appointment reminders, birthday cards, holiday cards and other correspondence may be sent to your address. By signing this form, you are giving authorization to contact you with these reminders and information.

Informed Consent to Acupuncture and Oriental Medical Care

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturist on staff : acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation of a variety of areas of my body, observation, range of motion, muscle, and orthopedic testing; modes of manual or physical therapy such as Zen Shiatsu, Tuina, manipulation of joints or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; the prescription of herbal and homeopathic medicines as well as dietary supplements, dietary recommendations; exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with my acupuncturist, the nature and purpose of acupuncture and Oriental Medicine procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Oriental Medicine there are some risks of treatment, I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, Pneumothorax (punctured lung), puncture of other organs, pain or other strong sensation at the location of needle insertion or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms, general aches, sprains, strains, dislocation, fractures, disc injuries, and strokes. I do not expect the acupuncturist to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise such judgment, during the course of my treatment, as the acupuncturist feels at the time, based on the facts known, to be in my best interest. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I release Jason Laird, L. Ac., his employees and assigns from any of the above risks.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from this clinic.

LIABILITY RELEASE, WAIVER, DISCHARGE AND COVENANT NOT TO SUE

This is a legally-binding Release made by me, to Jason Laird, L. Ac., and the Rising Lotus Wellness Center. I fully recognize that there are dangers and risks to which I may be exposed by receiving acupuncture. I understand that I want to receive acupuncture despite the possible dangers and risks, and despite this Release. I release Jason Laird, L. Ac., the Rising Lotus Wellness Center, its employees and agents from any and all liability, claims and actions that may arise from injury or harm to me, from my death or from damage to my property. I understand that this Release covers liability, claims and actions caused entirely or in part by any acts or failures to act by Jason Laird, L. Ac., Rising Lotus Wellness Center, its employees or agents including but not limited to negligence, mistake, or failure to supervise. I recognize this entire Release means I am giving up, among other things, rights to sue Jason Laird, L. Ac., the Rising Lotus Wellness Center, its employees and agents for injuries, damages, or losses I may incur. I also understand that this Release binds my heirs, executors, administrators, and assigns, as well as myself. I have read this entire Release, I fully understand it and I agree be legally bound by it.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Patient Name or Patient Representative
(Please Print)

Date

Patient Signature or (Patient Representative)

Acupuncturist Signature