www.bluelotussantafe.com

Demographic Information

Name: _____ Date of Birth: _____

Address: _____ City_____State_____ZIP_____

Phone numbers: Home_____ Work_____ Cell_____

Email Addresss: _____

Employer: _____

Occupation: _____

Spouse/Partner Name: _____Phone:_____

Emergency Contact: _____Phone:_____

Insurance Information

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____

SS/Insurance ID#:_____Group/Account#:_____

Referred by:_____

Authorization to Release Information

Blue Lotus Health Essentials, Inc. is authorized to release to any health insurance companies having coverage on me or my dependents, all medical records pertaining to my, or my dependents' treatments. They are further authorized to initiate health insurance claims in my name and to receive direct payment from my health insurance for health services provided. I understand that I am financially responsible for any balance due, in the event that my health insurance does not cover, for any reason, the treatment/s I have received while a client of Blue Lotus Integrative Healing Arts.

A photo-static copy of this authorization shall be considered as effective as an original.

Patient's Signature: _____ Date: _____

Medical Questionnaire

Name _____Date of Birth _____

Health concerns (i.e. pain, sleep, stress, weight, etc) in order of importance:

_____
_____
_____
_____
_____

Health goals (i.e. more energy, better sleep, balanced mood etc) :

_____
_____
_____
_____

Pain or Problem started on _____

Pains are: O Sharp O Dull/Ache O Constant O Intermittent O Other_____

Does this pain shoot, radiate, or travel in your body? _____

Where?_____

Are you experiencing numbness or tingling in any area of your body and where?

_____

Since it began, is it: O Same O Better O Worse

What activities aggravate your condition/pain?_____

What activities lessen your condition/pain?_____

When and where are your symptoms worse? O At home O At work O Upon waking

O Morning O Afternoon O Evening O Overnight O No pattern

Is this condition interfering with O Work? O Sleep? O Routine? O Other?_____

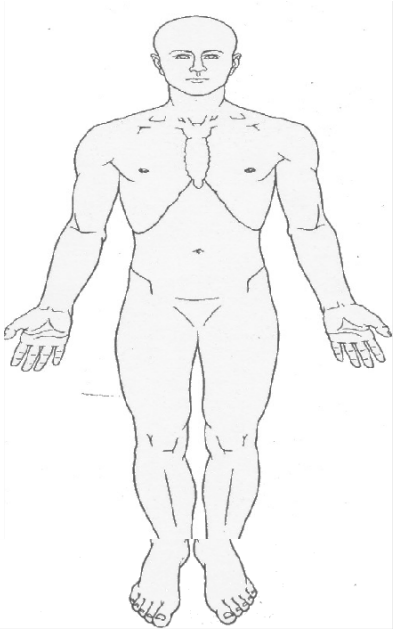
Other Doctors seen for this condition_____

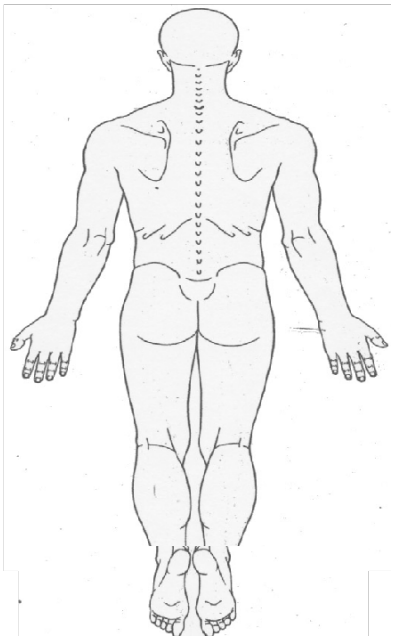
Any home remedies used?_____

Pain Severity:

(No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Using the symbols below, mark on the pictures where you feel pain.





Numbness === Dull

Ache OOO Burning

XXX Sharp/Stabbing

///

Other_____ ^^^

Have you been to a Doctor of Oriental Medicine before? _____ If so, when & for what circumstance?

_____

Have you been to a Doctor or Chiropractic before? _____ If so, when & for what circumstance?

_____

Have you ever had Massage Therapy before? _____ If so, when & for what circumstance?

_____

Who is your General Practitioner?_____

When did you last receive medical care? _____

Where? _____ Why?_____

_____

Health History

Please list any known allergies (environmental, drug, food):

_____

Do you take any of the following over-the-counter medications? Please check any that apply:

O Aspirin O Ibuprofen or acetaminophen O Antihistamine O Sleeping pills
O Laxatives O Appetite depressants O Antacid O Medicine to stay awake

Please list any **pharmaceutical** and/or **supplements** (including vitamins) that you are taking or have taken in the last year: (continued on next page)

MEDICATION	DOSAGE	DATES	REASON FOR TAKING

If any of the following apply to you, please indicate dates and reason:

Hospitalization _____ Endoscopy _____
Surgery _____ Colonoscopy _____
X-ray _____ Mammogram _____
MRI _____ CT scan _____
Rectal exam _____ Bone Scan_____
Electrocardiogram _____ Other _____
Motor Vehicle Accident_____ Trauma/Accident_____

For the following conditions and symptoms, please indicate any that apply to you by marking "O" for *Occasional*, "F" for *Frequent* and "S" for *Severe*:

___ Skin rash
___ Anemia
___ Easy bleeding or bruising
___ Varicose veins or hemorrhoids
___ Bone or joint disease
___ Digestive disorder
___ Anxiety or nervousness
___ Difficulty sleeping
___ Feel unsafe at home
___ Physical abuse
___ Frequent antibiotic use
___ Frequent colds or flu
___ Urination problems
___ Lyme disease
___ Rheumatic fever
___ Vaccinations
___ Frequent colds
___ Abdominal pain
___Neck Pain
___Back Pain

___Chronic pain
___Difficulty breathing
___Heart palpitations
___Dizziness or fainting
___Numbness/tingling/paralysis
___ Neurological disease
___Gastritis or ulcers
___Memory loss
___Excessive thirst/hunger
___Head injury
___Dental problems
___Gallbladder disease
___Ear infections
___Impaired hearing /vision
___Sinus problems
___Thyroid problems
___Asthma
___ Eye problems

___Fatigue
___Chest pain
___Weakness
___Atherosclerosis
___Mood swings
___ Heartburn
___Seizures
___ Headaches
___ Hypoglycemia
___Eating disorder
___Parasites
___Liver disease
___Cold sores
___Kidney disease
___HIV/AIDS
___Sexual difficulties
___ Allergies
___ Ringing in ears

Other_____

Family History

If **you** or **anyone in your immediate family** has or had any of the following conditions, please indicate who was affected (self, mother, father, sister, brother, child):

Cancer _____ Diabetes _____
Heart Disease _____ Asthma, hay fever, rashes_____
Stroke _____ Osteoporosis _____
High blood pressure _____ Depression _____
Alcoholism or substance abuse_____ Autoimmune disease _____
Attempted suicide _____ Arthritis_____
Other:

For Men Only

Please check all that apply to you:

___ Prostate exam _____ /_____/_____
___ Regular self testicular exam
___ Impaired fertility
___ Sexual abuse
___ Abnormal discharge from penis
___ Pain or lump in scrotum
___ Prostate problem:
___ Sexually transmitted infection

Other:

For Women Only

Last menses _____ / _____ / _____
Last pap smear _____ / _____ / _____
Age menses began _____
Number of pregnancies _____
Number of live births _____

If you are still having periods:
Are you currently pregnant? Y N ?
Number of days of bleeding:
Average number of days in cycle:
Bleeding is: ___ Regular ___ Irregular
___ Light ___ Medium ___ Heavy
___ Bleeding btn periods ___ Mood swings
___ Painful menses ___ Breasts tender
___ PMS ___ Clots ___Headache

If you are no longer having periods:
___ Hot flashes___ Vaginal dryness
___ Facial hair ___Changes in memory
___ Dry skin ___ Changes in libido
___ Changes in mood
___ Hair loss ___ Incontinence

___ Hormone replacement therapy

Please check all that apply to you:
___ Hysterectomy date:
___ Abnormal pap smear
___ Breast pain/lump/discharge
___ Sexual difficulties
___ Vaginitis / chronic yeast infections
___ Abnormal vaginal discharge
___ Endometriosis
___ Polycystic ovary syndrome
___ Sexually transmitted infection
___ Pelvic inflammatory disease
___ Uterine fibroids
___ Sexual abuse
___ Sexually transmitted infections
___ Regular self breast exam
___ Sexually active
___ Contraceptive use
___ Urinary tract infections
___ Spotting
___ Other

Lifestyle History

Please check any that apply to you and fill in corresponding details:

Exercise _____hours per week _____
Activities _____ Weight:
Watch TV _____hours per week _____ Weight last year:
Coffee use _____ cups per day _____ Height:
Tobacco use _____ packs per day _____
Alcohol use _____ drinks per week_____ When? _____
Recreational drug use _____
Sleep _____ hours per night _____ Is this enough? _____
Mercury amalgam fillings:
Exposure to radiation:
Flu Shots:
Long term prescription drug use?
Employed outside the home?
Occupation _____

Hours per week _____

Employer _____

Do you enjoy your work? ___ Yes ___ No

Level of stress ___Low ___Average ___High

What do you commonly eat? (Please be detailed)

breakfast:

lunch:

dinner:

snacks:

What foods do you crave?

Do you eat “out” often?

Dietary restrictions:

Bowel movements per day: soft___ hard___ alternating___

Major life change in last year:

_____

_____

_____

anything else you’d like us to know:

_____

_____

_____

_____

BLUE LOTUS
INTEGRATIVE HEALING ARTS

BLUE LOTUS CANCELLATION and NO-SHOW POLICY

We ask that you give us advance notice of 24 hours if you are unable to keep your appointment.

Same day cancellations do occur and we will allow for a ONE time amnesty.

The second last minute cancellation will result in a $45.00 charge.

Please understand that our therapists have this time blocked for you and we need time to fill the schedule. We will kindly make exceptions in the case of illness or family emergencies.

NO SHOW POLICY

No shows will be charged:
Massage $80.00
Acupuncture $90.00
Chiropractic $60.00

Please note that we provide written and/or printed appointment dates and times. We send automated text messages (as a courtesy) and document everything in our scheduling software to ensure you are aware of your appointments. It is the patient's responsibility to inform us if you are unable to make your appointment.

Thank you!!

Staff at Blue Lotus

BLUE LOTUS INTEGRATIVE HEALING ARTS www.bluelotussantafe.com
422 A Medico Lane Santa Fe, NM 87505 phone (505) 986-9109 fax (505) 989-3221

HIPAA Notice Of Privacy Practices

This notice describes how medical information about you may be used and disclosed. As well as how you can access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1998("HIPAA") is a federal program that requires that all records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entitles that misuse personal health information.

As required by "HIPAA", we Blue Lotus Integrative Healing Arts/ AKA the practice of Blue Lotus Health Essentials Inc., have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose of your medical records only for each of the following purposes: 1. Treatment 2. Payment, 3. Health Care Operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health Care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost- management analysis, and customer service. Examples include an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are require to honor and abide by that written request, except to the extent that we have already taken actions replying on your authorization.

You have the following rights with respect to your protected health information (PHI), which you can exercise by presenting a written request to the Privacy Officer. The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members or other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a request restriction. If we do agree restriction, we must abide by it unless you agree in writing to remove it.

The right to inspect and copy your protected health information.
The right to amend your personal health information.
The right to receive an accounting disclosures of protected health information.
The right to obtain a paper to obtain a paper copy of the notice from us upon request.

We are required by law to maintain the privacy of your PHI and to provide you with our legal duties and privacy practices with respect to PHI. This notice is effective as of April 1,2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Policy Practices and to make he new notice provisions effective for all PHI that we maintain. We will post and you may request a written copy of a Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have be violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact the following office for more information For more information about HIPAA, or to file a complaint:
The U.S. Department of Health & Human Services-Office of Civil Rights, 200 Independence Avenue, S.W. , Washington, D.C. 20201 1-(202) 619-0257 Toll Free 1(877) 696-6775

Signature: _____ Date: _____

Informed Consent

Dear Patient:

I hereby request and consent to the performance of chiropractic treatments. This is inclusive of other procedures within the practice and scope of Chiropractic care. I consent to my provider ordering and/or reviewing lab tests, x-rays, and reports, knowing that all my records will be kept confidential according to the law and will not be released without my written consent. I also consent to receiving massage and exercise instruction as part of my chiropractic visit. Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. Chiropractic adjustments are the moving of bones with the physician's hands or with the use of a machine. Frequently, adjustments create a popping or clicking sound/ sensation in the areas being treated. There can be other problems or complications that might arise from chiropractic treatment other than those noted below. These other problems and complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of the treatment.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The chiropractic adjustment that is related to the vertebral artery stroke is called Extension-Rotation-Thrust Atlas Adjustment. We Do NOT use this type of adjustments on our patients. Other type of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (journal of CCA Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractic would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disk Herniations: Disc herniations that create pressure on a spinal nerve or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustment, traction, etc. This includes both in the neck and the back.

Yet, occasionally, chiropractic treatment will aggravate the problem and rarely, surgery may cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue primarily refers to muscles, tendons, ligaments, and fascia. Muscles and tendons help move bones whereas ligaments limit joint movement. Rarely, a chiropractic adjustment or treatment may cause tearing of these fibers and /or scar tissue that is built up around joints. The result is a temporary increase in pain and necessary treatments for resolution but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or mid-back. They extend from your back to the chest area. Rarely a chiropractic adjustment will crack a rib bone and this is referred to as a fracture. This occurs only with patients who have weakened bone structure from conditions such as osteoporosis.
Many disease processes that affect bone density can be detected with X-rays. We take great care to treat all patients very carefully, especially those who have issues that are revealed on their X-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some physiotherapeutic devices generate heat. Everyone's skin has different sensitivity and rarely heat can cause skin irritation and/or blistering. This is a rare occurrence and there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic treatments, traction, massage therapy, exercise, etc. to result in a temporary increase in the region being treated. This is nearly always a temporary symptom that occurs when the body is undergoing therapeutic changes. It is not dangerous but if it occurs please be sure to inform your physician.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than what is noted above. These problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic.
We will always provide you with the best care that we can and if the results are not acceptable, we will gladly refer you to another health care provider who may be able to help your condition.

If you have any questions on the above information, please do not hesitate to ask. If you feel you have a full understanding of this form, please sign and date below.

I hereby request and consent to the performance of chiropractic, acupuncture and/or massage therapy treatments, including other procedures within the scope of the practice, on me (or on the patient named below for whom I am legally responsible). This also includes manual therapy, also known as medical massage, by a licensed massage therapist (LMT).

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical acupoint stimulation, Tui-na (Oriental medical massage), manual therapy (also known as medical massage), Qi-gong (Oriental energy medicine), Oriental herbal medicine, nutritional counseling and nutritional supplementation. I understand that the herbs prescribed may need to be prepared, and herbal teas consumed according to the instructions provided verbally and in writing. I realize that the herbs may have an unpleasant smell or taste. I will immediately notify my provider or a member of her clinical staff in the case of any unanticipated or unpleasant effects associated with the consumption of herbs or nutritional supplements.

I am informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases dizziness or even fainting. Bruising is a common and often intended effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although my provider exclusively uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects or risks may occur. The herbs and nutritional supplements used by my provider (which are from plant, animal, and mineral sources and include herbal or homeopathic medicine, vitamins, enzymes, glandular products, amino acids, and OTC dietary / nutritional supplements) are considered safe in the practice of Oriental Medicine and/or are within the scope of practice for a D.O.M. licensed in the state of New Mexico.

I do not expect my provider to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her/him to exercise judgment during the course of treatment which s/he thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed, and that I can refuse any aspect of treatment at any time.

I consent to my provider ordering and/or reviewing lab tests or reports, knowing that all my records will be kept confidential according to the law, and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, understand the risks and benefits of Oriental Medical treatment, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Patient Name (Printed):_____ ***Date:***_____

Patient Signature:_____

Informed Consent for a Minor

I _____ hereby give permission (until further notice) to Blue Lotus Integrative Healing Arts to provide my minor child/person under my guardianship with therapeutic massage, acupuncture, chiropractic or any other healing modality provided within association or direct referral from our Doctors on staff at Blue Lotus as deemed appropriate to treat presenting conditions/ injuries. I understand that I am financially responsible for the treatment, and that all statements contained in this consent apply equally to myself and to the minor.

Parent/Guardian Signature: _____ ***Date:*** _____