



**Lotus Acupuncture & Holistic Health Clinic**  
 3637 Virginia Beach Blvd. Virginia Beach, VA. 23452  
 Email: [info@lahhc.com](mailto:info@lahhc.com) Phone: 757.431.0053

*Nutritional Response Therapy*  
**New Patient Information Form**  
 Page 1 of 2

Please print clearly:

**Patient Information**

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Apt. # \_\_\_\_\_  
 City \_\_\_\_\_ ZIP \_\_\_\_\_

Please put a star by preferred phone:

Home phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Referred By:** \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: M/F Height \_\_\_\_\_ Weight \_\_\_\_\_

**Current Health Concerns**

Overall Health ( circle one ): Excellent / Good / Fair / Poor / Other: \_\_\_\_\_

Chief complaint ( reason you are here ): ( use back of sheet if more room needed)

Previous treatments for this complaint \_\_\_\_\_

Other complaints or problems: (use back if needed) \_\_\_\_\_

Current medications/drugs being taken: (use back is needed) \_\_\_\_\_

Are you currently under the care of a physician or other health care professionals?

(if yes, please give name and date of last visit):

Nutritional supplements you are taking: \_\_\_\_\_

Do you smoke, drink coffee or alcohol? (if yes, indicate how much)

Cigarettes \_\_\_\_\_ Coffee \_\_\_\_\_ Alcohol \_\_\_\_\_

**Health History/ Family**

List any major illnesses (with approx. dates): \_\_\_\_\_

List any surgery or operations with approx. date: \_\_\_\_\_

Past Accidents or injuries: \_\_\_\_\_

\_\_\_\_\_



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**Health History/ Family (Cont'd)**

Marital Status (circle): Single      Married      Divorced      Widowed      Domestic Partnership

Name of Spouse/ Partner: \_\_\_\_\_

Describe health of Spouse/ Partner: \_\_\_\_\_ Number of children if any \_\_\_\_\_

Name of Child	Age	Sex	Any physical conditions or concerns?
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_____	_____	M/F	_____
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_____	_____	M/F	_____
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_____	_____	M/F	_____
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Any family history of serious illnesses ( circle those which apply): \_\_\_\_\_

Any household pets or other animals you or family members are in close contact with: \_\_\_\_\_

**Dietary Intake for 2 days before appointment**

Breakfast: \_\_\_\_\_ Breakfast: \_\_\_\_\_

Snacks: \_\_\_\_\_ Snacks: \_\_\_\_\_

Lunch: \_\_\_\_\_ Lunch: \_\_\_\_\_

Snacks: \_\_\_\_\_ Snacks: \_\_\_\_\_

Dinner: \_\_\_\_\_ Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_ Snacks: \_\_\_\_\_

What can we do to make you happier? \_\_\_\_\_

\_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_