Whispering Lotus Healing Center
4222 W Emerald Street, Boise, ID 83706 | 208-901-8556 | www.whisperinglotus.com

New Patient Checklist

1. Please print this 7-page document, complete it as best you can, and bring it with you to your appointment.
    - If you are unable to print out the New Patient Intake Form, please contact our office at 208-901-8556 to discuss other options.
    - Please allow ~ 30 minutes to complete the New Patient Intake Form.
2. NAET allergy desensitization patients please read NAET Instructions and signed the NAET Informed Consent.
3. You are welcome to bring recent **laboratory reports** related to the treatment conditions you are seeking support for.
    - To request records transferred from other providers, you can find a Release of Records form on our web page.
4. Please be conscientious and avoid fragrances. When you visit our office, please do not wear scents that are perceptible by others, such as: perfume, cologne, scented hair spray, scented deodorant, scented lotion, or strong essential oils. We appreciate your respect to our chemically sensitive patients and staff.
5. Please review and sign our Fees and Services and HIPPA policies.
6. Please be aware of our **Cancellation Policy:**
    - You may cancel or reschedule at *no charge* if you call **at least 24 hrs (1 business day)** before your appointment. If notice is given less than twenty-four hours, you will be charged **half price of the visit**.

If you have any questions, please contact us at 208-901-8556. Office hours are 9 to 5 Monday to Thursday. Responses will be made the next business day.

Thank you! We look forward to meeting you and helping you on your journey to good health!

ADULT PATIENT INTAKE FORM **WHISPERING LOTUS HEALING CENTER**

Today's Date______________________

PERSONAL INFORMATION

Full Name____I like to be called _________________________
(First Middle Initial Last)

Age_______________________Date of Birth___________________________________Gender____________________

Address____

City_____________________________State____________________________ Zip____________________________

Phone (best)____(alternate)___________________________________

May we leave a confidential message? Yes / No

Email ____

Occupation____ Hours per week?____________

Employer ____

Education____ Military Service?____________

Who do you live with?____

Do you have children? Yes / No If YES, what are their ages:____

Emergency Contact____Relationship_____________________

Contact's Phone ____

Who is your primary care provider?____

Please list other providers/specialists involved in your care:____

____

How did you hear about our clinic? (check all that apply)

- ☐ Friend/Family
- ☐ Walk/Drive by
- ☐ Other ___________________
- ☐ Event/Talk
- ☐ Website
- ☐ Social Media
- ☐ Physician/Health Care Provider referral ____

Would you like to receive our Monthly Email Newsletter with clinic news and event listings? Yes / No

What goals and health concerns bring you to the clinic today?

____ ____

____ ____

____ ____

MEDICAL HISTORY

When was your last physical?_______________________ When did you last have bloodwork?________________________

What is your blood type (A/B/O)?____________________

Do you have any implants (including medical devices), transplants, or artificial joints?_______________________________

Do you have any missing body parts?____

Height__________Weight__________Weight 1 year ago__________Maximum Weight__________When?____________

Did you have standard childhood immunizations? Yes / No

Have you had immunizations for military or travel outside the US? Yes / No

Any negative reactions to vaccines? Explain:____

Approximately how many times in your life have you had antibiotics?____

Please list any surgeries or mental for physical health hospitalization:	Approximate date, year, or age

Are you allergic to any medications or have had an allergic reaction to anything else? Yes / No (food reactions, see pg 3)

If Yes, please explain:____

PERSONAL AND FAMILY MEDICAL HISTORY

Have **YOU or a FAMILY MEMBER** ever had any of the following medical conditions?

Condition	Self	Family	Condition	Self	Family
Alcoholism/Addiction	☐ Self	☐ Family ____________	Heart Attack	☐ Self	☐ Family ____________
Anxiety	☐ Self	☐ Family ____________	Heart Disease	☐ Self	☐ Family ____________
Asthma	☐ Self	☐ Family ____________	High Cholesterol	☐ Self	☐ Family ____________
Autoimmune Disease	☐ Self	☐ Family ____________	High Blood Pressure	☐ Self	☐ Family ____________
Birth Defects	☐ Self	☐ Family ____________	HIV/AIDS	☐ Self	☐ Family ____________
Cancer, Type?_____________	☐ Self	☐ Family ____________	Insomnia	☐ Self	☐ Family ____________
			Mental Illness	☐ Self	☐ Family ____________
Chemical Sensitivity	☐ Self	☐ Family ____________	Obesity	☐ Self	☐ Family ____________
Deep Vein Thrombosis	☐ Self	☐ Family ____________	Osteoporosis/ Osteopenia	☐ Self	☐ Family ____________
Depression	☐ Self	☐ Family ____________	Pulmonary Embolism	☐ Self	☐ Family ____________
Diabetes/ Pre-Diabetes	☐ Self	☐ Family ____________	Self-Harm	☐ Self	☐ Family ____________
			Sickle Cell Anemia	☐ Self	☐ Family ____________
Easy Bleeding	☐ Self	☐ Family ____________	Skin Disease	☐ Self	☐ Family ____________
Eczema	☐ Self	☐ Family ____________	Sleep Apnea	☐ Self	☐ Family ____________
Emphysema	☐ Self	☐ Family ____________	Stroke	☐ Self	☐ Family ____________
Epilepsy or Seizures	☐ Self	☐ Family ____________	Suicide/Attempt	☐ Self	☐ Family ____________
Food Allergies	☐ Self	☐ Family ____________	Tuberculosis	☐ Self	☐ Family ____________
Food Sensitivities	☐ Self	☐ Family ____________	Thyroid Disease	☐ Self	☐ Family ____________
Glaucoma	☐ Self	☐ Family ____________	Ulcers	☐ Self	☐ Family ____________
Gout	☐ Self	☐ Family ____________	Other	☐ Self	☐ Family ____________
Hay Fever	☐ Self	☐ Family ____________			

THERAPIES

Please list all supplements and medications you are currently taking. Attach another page if needed.
Bringing bottles to your visit is helpful.

Name of current medication/supplement (such as Synthroid, Vitamin D, etc.)	**Strength** (such as 250 mg)	**Directions** (such as 1 tablet twice a day, as needed, etc)

Have you tried other therapies for your health concerns? Yes / No. If yes, please describe:___________________________

____

____

NUTRITION & LIFESTYLE

Do you follow any particular diet philosophy? Yes / No If Yes, please describe:_____________________________________

____

Please list foods you commonly eat:
Breakfast____
Lunch____
Dinner____
Snacks____
How much water and other fluids do you drink a day?________________________Do you use a water filter?_____________
What food(s), condiments(s), or any other substances (e.g. tobacco, alcohol, coffee, etc.) do you crave?

____

Do you have a sensitivity/intolerance/allergy to any foods? Yes / No Explain:____

____

How much sleep do you get a night?_________________Is it enough? Yes / No Do you wake during the night? Yes / No
Do you wake refreshed in the morning? Yes / No
Do you smoke? Yes / No Do you vape? Yes / No
Are you exposed to chemicals? Yes / No Explain:____
Do you exercise regularly? Yes / No How often?____________________ What type?________________________________

REVIEW OF SYMPTOMS

Please circle 1 (mild), 2 (moderate), or 3 (severe) if any of the following apply to you:

	Now	Past		Now	Past	
General	1 2 3	1 2 3	swollen or painful lymph nodes	1 2 3	1 2 3	excessive hair growth
	1 2 3	1 2 3	poor wound healing	1 2 3	1 2 3	bruise easily
	1 2 3	1 2 3	difficulty stopping bleeding	1 2 3	1 2 3	heat intolerance
	1 2 3	1 2 3	anemia	1 2 3	1 2 3	cold intolerance
	1 2 3	1 2 3	weakness	1 2 3	1 2 3	cold hands or feet
	1 2 3	1 2 3	fatigue	1 2 3	1 2 3	excessive thirst
	1 2 3	1 2 3	unexplained weight loss/gain	1 2 3	1 2 3	excessive hunger
	1 2 3	1 2 3	chemical sensitivity	1 2 3	1 2 3	excessive sweating

Gastrointestinal How often do you have bowel movements? ____________________________

	Now	Past		Now	Past	
	1 2 3	1 2 3	nausea	1 2 3	1 2 3	vomiting
	1 2 3	1 2 3	blood in stool	1 2 3	1 2 3	diarrhea
	1 2 3	1 2 3	constipation	1 2 3	1 2 3	hemorrhoids
	1 2 3	1 2 3	hard, dry stools	1 2 3	1 2 3	excessive gas
	1 2 3	1 2 3	ulcer	1 2 3	1 2 3	bloating
	1 2 3	1 2 3	anal itching	1 2 3	1 2 3	heavy, full feeling after eating
	1 2 3	1 2 3	heartburn	1 2 3	1 2 3	parasites
	1 2 3	1 2 3	excess belching	1 2 3	1 2 3	abdominal pain
	1 2 3	1 2 3	trouble swallowing			
	1 2 3	1 2 3	alternating constipation and diarrhea			
	1 2 3	1 2 3	change in bowel movements			
Skin and Nails	1 2 3	1 2 3	pimples/acne	1 2 3	1 2 3	hives
	1 2 3	1 2 3	color changes in nails	1 2 3	1 2 3	loss of hair
	1 2 3	1 2 3	skin infections	1 2 3	1 2 3	skin cancer
	1 2 3	1 2 3	skin rough, dry, scaly, bumpy, itchy (circles which apply)			
	1 2 3	1 2 3	rashes, warts, moles, cysts (circle which apply)			
	1 2 3	1 2 3	light or dark patches of skin (circle which apply)			
	1 2 3	1 2 3	increased hair growth in unusual places			
Head	1 2 3	1 2 3	dizziness	1 2 3	1 2 3	head injuries/concussion
	1 2 3	1 2 3	headaches	1 2 3	1 2 3	fainting spells
	1 2 3	1 2 3	migraines	1 2 3	1 2 3	seizures
Eyes	1 2 3	1 2 3	blurry vision	1 2 3	1 2 3	eye injuries
	1 2 3	1 2 3	double vision	1 2 3	1 2 3	eye pain, irritation
	1 2 3	1 2 3	corrective lenses	1 2 3	1 2 3	eye discharge / drainage
	1 2 3	1 2 3	eye infections	__________		approx. date of last eye exam
Ears	1 2 3	1 2 3	discharge	1 2 3	1 2 3	infections
	1 2 3	1 2 3	pain in ears	1 2 3	1 2 3	motion sickness/vertigo
	1 2 3	1 2 3	hearing trouble	1 2 3	1 2 3	ringing or roar in ear
	1 2 3	1 2 3	itching	1 2 3	1 2 3	stopped up ears

Please mark 1 (mild), 2 (moderate), or 3 (severe) if any of the following apply to you:

	Now	Past		Now	Past	
Nose	1 2 3	1 2 3	nosebleeds	1 2 3	1 2 3	difficulty breathing through nose
	1 2 3	1 2 3	sinus infections	1 2 3	1 2 3	loss of smell
	1 2 3	1 2 3	seasonal allergies	1 2 3	1 2 3	post-nasal drip
	1 2 3	1 2 3	snoring	1 2 3	1 2 3	sleep apnea or wake gasping for air
Mouth	1 2 3	1 2 3	cold sores/canker sores	1 2 3	1 2 3	root canals
	1 2 3	1 2 3	speech difficulties	1 2 3	1 2 3	infections
	1 2 3	1 2 3	loss of teeth	1 2 3	1 2 3	dryness
	1 2 3	1 2 3	grinding teeth	1 2 3	1 2 3	bad breath
	1 2 3	1 2 3	sore jaw	1 2 3	1 2 3	bad taste
	1 2 3	1 2 3	gum problems	1 2 3	1 2 3	amalgam (silver) fillings
Throat	1 2 3	1 2 3	loss of voice	1 2 3	1 2 3	pain
	1 2 3	1 2 3	infections	1 2 3	1 2 3	swelling/constriction
	1 2 3	1 2 3	persistent hoarseness	1 2 3	1 2 3	difficulty swallowing
	1 2 3	1 2 3	tonsils or adenoids removed			
Neck	1 2 3	1 2 3	stiffness/pain	1 2 3	1 2 3	injuries / whiplash
	1 2 3	1 2 3	swollen glands	1 2 3	1 2 3	enlarged thyroid
Respiratory						
	1 2 3	1 2 3	shortness of breath	1 2 3	1 2 3	wheezing/asthma
	1 2 3	1 2 3	coughing spells	1 2 3	1 2 3	infections
	1 2 3	1 2 3	expectoration (mucus, blood)	1 2 3	1 2 3	chest pain with breath
Cardiovascular						
	1 2 3	1 2 3	heart disease	1 2 3	1 2 3	high cholesterol
	1 2 3	1 2 3	chest pain	1 2 3	1 2 3	leg vein trouble
	1 2 3	1 2 3	shortness of breath	1 2 3	1 2 3	murmur
	1 2 3	1 2 3	irregular heart beat or palpitations	1 2 3	1 2 3	ankle or foot swelling
Urinary	1 2 3	1 2 3	frequent urination	1 2 3	1 2 3	painful urination
	1 2 3	1 2 3	night urination	1 2 3	1 2 3	foul odor/unusual color of urine
	1 2 3	1 2 3	trouble starting urine	1 2 3	1 2 3	trouble holding urine
	1 2 3	1 2 3	prolapsed bladder	1 2 3	1 2 3	frequent urinary tract infections
	1 2 3	1 2 3	kidney stones			
Male	1 2 3	1 2 3	discharge from penis	1 2 3	1 2 3	painful erection
	1 2 3	1 2 3	infertility	1 2 3	1 2 3	infection
	1 2 3	1 2 3	prostate problems	1 2 3	1 2 3	injury
	1 2 3	1 2 3	sexually transmitted disease	1 2 3	1 2 3	lumps, swelling, or pain in testicles
	1 2 3	1 2 3	difficulty achieving or maintaining an erection			

What kind of contraception do you use?____

Do you want birth control information? Yes / No

Please mark 1 (mild), 2 (moderate), or 3 (severe) if any of the following apply to you:

	Now	Past		Now	Past	
Female	1 2 3	1 2 3	discharge from vagina	1 2 3	1 2 3	painful intercourse
	1 2 3	1 2 3	pelvic pain	1 2 3	1 2 3	flushes of heat
	1 2 3	1 2 3	infertility	1 2 3	1 2 3	prolapsed uterus
	1 2 3	1 2 3	menstrual flow is excessive	1 2 3	1 2 3	difficulty feeling sexually aroused
	1 2 3	1 2 3	menstrual flow is absent	1 2 3	1 2 3	no lubrication when aroused
	1 2 3	1 2 3	menstrual flow is irregular	1 2 3	1 2 3	never or seldom have orgasms
	1 2 3	1 2 3	spotting between periods	1 2 3	1 2 3	sexually transmitted disease

1 2 3 1 2 3 infection: Type/Location?_________________When?__________________

Breasts: (circle) lumps, swelling, soreness, biopsies, family history of breast cancer

Premenstrual symptoms: (circle) cramping, water retention, breast tenderness, headaches, depression, irritability, others__________________________________How severe?___________________________

What kind of contraception do you use?____

Do you want birth control information? Yes / No

First day of last menstrual period?___________________

Usual # of days of spotting & bleeding?_______________How often does your period come?_______________

Have you had a hysterectomy? Yes / No Date: _______________ Do you still have your ovaries? Yes / No

Number of pregnancies?_________ Number of births?_________ Any incomplete pregnancies? Yes / No

Approximate date of last pap test?___________________Ever had an abnormal pap smear? Yes / No

Approximate date of last mammogram or thermography? _______________________

	Now	Past	
Musculo-skeletal	1 2 3	1 2 3	pain or stiffness. Where?____________________________________
	1 2 3	1 2 3	swelling. Where?____
	1 2 3	1 2 3	injury. Where?____
	1 2 3	1 2 3	muscle cramps. Where?_____________________________________
	1 2 3	1 2 3	other. Describe:____

Neurological

Now	Past		Now	Past	
1 2 3	1 2 3	loss of balance	1 2 3	1 2 3	paralysis
1 2 3	1 2 3	faintness	1 2 3	1 2 3	lack of strength
1 2 3	1 2 3	involuntary movement	1 2 3	1 2 3	speech slurred
1 2 3	1 2 3	loss of consciousness	1 2 3	1 2 3	convulsions (seizures)
1 2 3	1 2 3	tremor (shaking, trembling)	1 2 3	1 2 3	numbness. Where?__________

Mental & Emotional

In the past few months, how often have you been bothered by any of the following problems?	**Not at all**	**Occas-ional Days**	**More Than Half the Days**	**Nearly Every Day**
Under excess stress				
Loss of interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling asleep, staying asleep or sleeping too much				
Difficulty with concentration or memory				
Feeling jumpy or easily started				
Excessive worry or anxiety				
Traumatic experiences in the past that still affect you				
Overuse of drugs or alcohol				
Thoughts you would be better off dead or of hurting yourself				

Do you currently suffer with an eating disorder				
Have you suffered in the past with an eating disorder				

FINAL NOTES

What do you think causes or has contributed to your health problems?____________________

What do you feel needs to happen for you to get better?____________________

What do you enjoy most in your life?____________________

What potential obstacles do you foresee in your journey to better health?____________________

____

How much change are you willing to make at this time for improving your health? (circle)

MINIMAL SOME COMPLETE

Is there anything else you wish to add?____________________

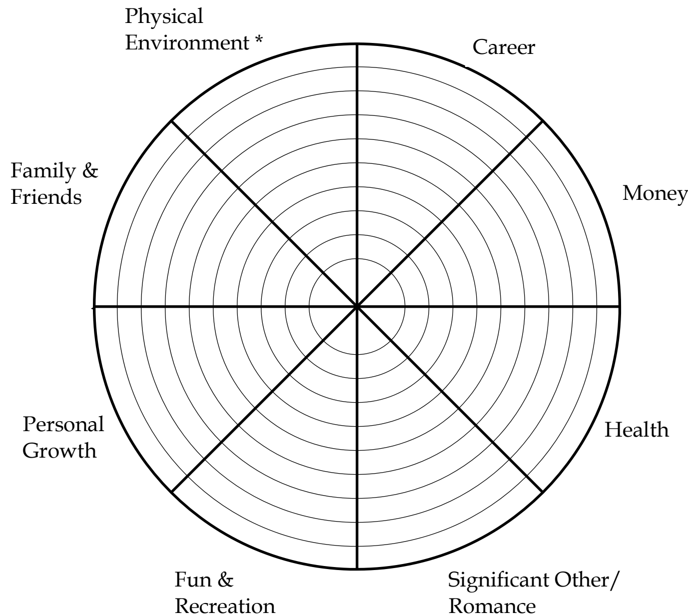
____

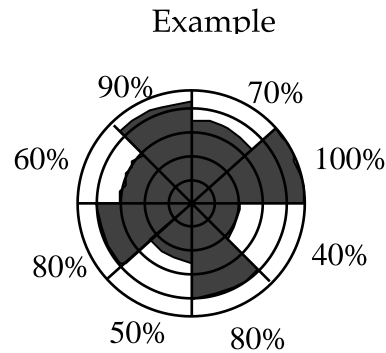
____

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you. For example, if you are extremely happy in your career, shade the entire pie shape for career. Do the same for each area, starting from the center point radiating outwards.

*Physical Environment means – Do you like your home, your work space, do you get enough fresh air, good light?





Thank you for taking the time to complete this form.
We look forward to providing you the best possible care.