Essence of Health

MEDICAL HISTORY RECORD

Acupuncture

Name: Last:_____First:_____ Middle:_____

Today's Date:_____Birth Date:_____ ☐ Male ☐ Female

Marital Status:_____Phone Number:_____ Email_____

Address:_____ City _____ State _____ Zip _____

Person to notify in Emergency:_____Phone Number_____

Do you	yes	no	Daily consumption	Operations and date. Diseases requiring hospitalization.	Serious diseases not requiring hospitalization.
Smoke			pkg		
Drink coffee			cup		
Drink Alcohol					
Drink Beer			glass		
Fall asleep easily					
Awaken easily					

WOMEN ONLY:	Yes	No	**WOMEN ONLY:**	Yes	No
Are you still having regular monthly menstrual periods?			Do you regularly have a PAP test?		
Any bleeding between periods?			How many children born alive?		
Any heavy bleeding between periods?			How many stillbirths?		
Feel bloated and irritable before periods?			How many premature births?		
Do you take birth control?			Date of last menstrual period?		
Have you ever had a miscarriage?			How many miscarriages?		
Have you ever had a discharge from the breast nipple?			How many cesarean operations?		
Any complications of pregnancy?					
MEN ONLY:			**MEN ONLY:**		
Loss of sexual activity and for how long?			Hernia (rupture)?		
Treatment for genitals (Private parts)?			Prostate trouble?		
Discharge from penis?					

MEN AND WOMEN:	Yes	No	**MEN AND WOMEN:**	Yes	No
Do you frequently have severe headaches?			If you recently had Stomach pain?		
If yes: Do they cause visual trouble?			Does it occur 1-2 hours after food?		
Do they occur on one side of the head?			Brought on by eating fried, greasy food?		
Do they awaken you at night?			Does it awaken you at night?		
Do they feel like a tight hat band?			Is it relieved by antacid medications?		
Do they hurt most in the back of head?			Is it relieved with mild or eating?		
Does aspirin relieve them?			Is it made worse by eating?		
			Does bowel movement relieve it?		
Have you ever fainted?			Does it cause loss of appetite?		
Any dizziness?			Do you have nausea?		
Any weakness of arm or leg?			**Do you frequently have:**		
Ringing in ears?			Bleeding gums?		
Have you ever had a convulsion?			Trouble swallowing?		
Double vision?			Hoarseness?		
Nosebleeds?			Sore tongue?		
Pains in ears?			Nausea and vomiting?		
Have you ever had shortness of breath			Have you ever had palpitations?		
Have you ever had burning when urinating?			Tightness of chest with radiating pain in arm?		
Loss of control of bladder?					
Blood in urine?			Have you recently had pain in leg calves?		
Trouble urinating?			Have you recently had a change in bowel habit?		
Trouble holding urine?			Do you have diarrhea?		
			Do you have constipation?		
What do require treatment for today?					

LIST OF MEDICATION

ACUPUNCTURE INFORMATION AND INFORMED CONSENT

Acupuncture is performed by the insertion of sterile disposable acupuncture needles through the skin, and / or the application of heat or electrical stimulation to the skin, or both, at certain points on the body. The benefits and risks of receiving acupuncture and Oriental Medical treatment have been explained to me. Although rare, certain side effects may result from Acupuncture. I understand that each procedure or treatment has specific risks and benefits. I understand that the licensed acupuncturist may record medical and other information concerning my treatment in electronic and in other physical form. Such information may be released by the clinic for the purposes authorized on this form. I understand that portions of my medical records may be disclosed to qualified non-clinic personnel for the purpose of conducting scientific or statistical research, management or financial audits, licensure and program evaluation without my express consent.

I have been informed of the risk and benefits of the procedure and products listed below that apply to my treatment: Acupuncture needles to stimulate points and meridians, including the specific risks of needling certain points. The use of mechanical, magnetic or electrical stimulation of acupuncture points, particularly in instances where such stimulation is applied across the midline of the trunk or in patients with a history of heart trouble, moxabustion, herbs laser puncture, acupressure, cupping, Gua Sha, massage, herbal supplements, nutrition and food therapies. I have been informed and understand the risks and side effects listed:

Minor bruising.

Needle sickness

Broken needles

Pain at needle insertion site.

Infection

Potential side effects of nutritional supplements and herbs.

Marks after cupping and Gua Sha.

RECORDS RELEASE AUTHORIZATION:

I understand that I am responsible for my bill. I authorize payment directly to my clinician. I authorize the use of this form for all of my insurance submissions and companies. I permit a copy of this authorization to be used in place of the original. I direct my previous health care providers to release medical records to this clinic. I authorize my clinician to act as my agent to obtain payment from my insurance companies.This authorization is not intended to allow the release of records regarding my treatment for services requiring a restricted release under State or Federal Law.

Patient's Signature_____Date_____

Witness Signature_____Date_____

Consent to treat a Minor Child: I authorize_____ and whomever she designates as assistants to administer Acupuncture and Oriental Medicine care as deemed necessary to my_____(relationship).

Patient's Name_____

Adult's Signature_____Date_____