Essence of Health

MEDICAL HISTORY RECORD

Acupuncture

Name: Last:_____First:_____

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
Smoke?			pkg
Drink coffee?			cup
Drink Alcohol?			
Drink Beer?			glass
Drink Soda?			

HEADACHES	Yes	No	**DIGESTION**	Yes	No
Do you frequently have severe headaches?			Do you get Stomach pain?		
If yes: Do they cause visual trouble?			Do you have nausea?		
Do they occur on one side of the head?			Do you have acid reflux?		
Do they awaken you at night?			Do you have food allergies?		
Do they feel like a tight hat band?			Do you have food intolerances?		
Do they hurt most in the back of head?			Have you recently had a change in bowel habit?		
BATHROOM			Do you have diarrhea?		
Do you wake up for bathroom at night?			Do you have constipation?		
If yes: how often?			**DIET**		
SLEEPING			Do you eat 2 to 3 fruits a day?		
Do you sleep well?			Do you eat 2-3 different vegetables a day?		
Do you have trouble getting to sleep?			**EXERCISE and HOW?**		
Do you have trouble staying asleep?					
What do you 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_____