ESSENCE OF ACUPUNCTURE, LLC

Confidential Patient Information Sheet
Patient Information

Name					**Date:**		
Address					**Email :**		
City		**ST**	**ZIP**	**HT**	**WT**	**AGE**	**M_____**
Home Phone		**Cell Phone**		**Date of Birth / /**			**F_____**
Emergency Contact				**Phone**			

Single _____ Married _____ Domestic Partner _____ Divorced _____ Widowed _____ Separated _____

Primary Care Doctor	**Last Seen:**

How did you hear about us: Ad in: _____ Article in: _____ FB: _____ Twitter: ____

Talk at _____ Brochure _____ Business Card _____ Website _____ Referral_____

The information on pages 1-4 is true to the best of my knowledge.

I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Eloise Prescott 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

Signed: **Date:**

Parent/Guardian (if applicable)

Medical History

Reason for your visit today:
_____

_____

_____

Are you being treated for this condition by anyone else: _____ Yes _____ No

If yes, who? _____ Phone # _____

Has this condition been diagnosed by a Doctor?

If yes, Diagnosis _____ No _____

Have the treatments helped? _____Yes _____Somewhat _____ Not Much _____ Not at all

How does this condition affect you?

_____

How long have you have you had this condition? _____

Know or suspected allergies _____

Childhood diseases you may have had:
_____Chicken Pox _____Measles _____Mumps _____Rheumatic Fever _____ Diphtheria _____ Scarlet Fever _____ Other

ACCIDENT/HOSPITALIZATION/ SURGERIES OVER THE PAST TEN YEARS (TYPE)	REASON	DATE

General Health as a chld: _____ Excellent _____Good _____Average _____Poor		
Fathr Overall Health _____Good _____ Poor _____Age (at death) _____ Cause of death		
Mother Overall Health _____Good _____ Poor _____ Age (at death) _____ Cause of death		
HEALTH INVENTORY		
Cardiovascular Conditions:	**Musculo-Skeletal:**	Nausea Vomiting ____
Heart Disease _____	Neck/Shoulder Pain ____	Epigastric/Abdominal ____
Pacemaker _____	Muscle Spasms/Cramps ___	Pain ____
High Blood Pressure _____	Arm Pain _____	Passing Gas ____
Low Blood Pressure _____	Upper Back Pain _____	Heart Burn ng ____
Chest Pain _____	Mid Back Pain ____	Belching ____
Palpitations _____	Low Back Pain ____	Gall Bladder Disease ___
Stroke _____	Leg Pain ____	Gall Stones ___
Varicose Veins _____	Osteoporosis _____	Hemorrhoids ___
Edema _____	Arthritis _____	Constipation ___
Emotional/Mental	Joint Pain ____	Diarrhea ___
Clinical Depression ____	**Head, Eye, Ear, Nose and Throat**	Endocrine ___
Mild Depression _____	Impaired Vision ____	Hypothyroid ___
ADD or ADHD _____	Eye Pain/Strain ___	Diabetes Type I ___
Schizophrenia _____	Glaucoma ____	Diabetes Type II ___
Mood Swings ____	Glasses/ Cataracts ____	Night Sweats ___
Panic Attacks _____	Tearing/Dryness _____	Unusual Sweating ___
Nervousness _____	Impaired Hearing _____	Feeling Hot or Cold ___
Anxiety _____	Ear Ringing _____	Other ___
Alzheimer's _____	Earaches _____	Cancer __
Dementia _____	Ear Infection _____	Type ___
	Headaches ____	Fibromyalgia _____
	Sinus Problems _____	Lupus ____
Energy and Immunity	Nose Bleeds ___	Dyslexia ___
Chronic Fatigue Syndrome _____	Teeth Grinding ___	**Gastrointestinal**
General Fatigue ____	Frequent ore Throats ___	Stomach Ulcers ___
Slow Wound Healing ____	TMJ/ Jaw Problems ___	Changes in Appetite ___
Easy Bruising _____	Hay Fever ___	Candida ___
Chronic Infections _____	**Genito-Urinary Tract**	Anemia ___
Frequent Allergies _____	Kidney Disease ___	Rashes ___
Respiratory	Kidney Stones ___	Eczema/Hives ___
Pneumonia __	Painful Urination ___	Cold Hand/Feet ___
Asthma ____	Blood in Urine ___	Hemophilia ___
Frequent Common ____	Discharge ___	Thin/Graying Hair ___
Colds	Incontinence ___	Liver Condition ___
Difficulty Breathing ____	**Neurological** ___	Hepatitis A ___
Emphysema _____	Vertigo/Dizziness ___	Hepatitis B ___
Persistent Cough _____	Paralysis ___	Hepatitis C ___
Pleurisy _____	Numbness/Tingling ___	
Tuberculosis ____	Loss of Balance ___	
Shortness of Breath ___	Seizures/Epilepsy ___	

Men Only: Impotence _____ Vasectomy _____ Date: _____		
Prostate Problems: Testicular Pain/Redness /Swelling _____Low Libido _____Excessive Libido _____		
Seminal Emissions _____ Painful Intercourse _____		
Women Only: _____ Yes, I am pregnant _____ Maybe I am pregnant _____ No		
Birth Control	Type:	How Long:
Age at first period _____ Date of last menses _____ Age of menopause _____ Length of cycle _____		
Pregnancies _____ Births _____ Miscarriages _____ Hysterectomy _____ Yes _____ No		
Check all that apply:		
Clotting _____ Painful Periods _____ Heavy Flow _____ Scanty Flow _____ Bleeding Between Cycles _____		
Irregular Cycles _____Vaginal Discharge _____ Breast Lumps/ Tenderness _____ Nipple Discharge _____ Infertility _____		
Menopausal Symptoms _____ PMS _____		

Please list all prescription and over the counter medications you are currently taking:

DRUG NAME	REASON FOR TAKING	DOSE/FREQUENCY

Please list all supplements and herbs you are currently taking:

SUPPLEMENT	REASON FOR TAKING	POTENCY/FREQUENCY

RISK FACTORS REVIEWED		
1.	Diet	
2.	Exercise	
3.	Safety (seat belts, smoke detectors, firearms, violence)	
4.	Smoking	
5.	Alcohol and other drugs	
6.	STDs/Contraception	

DISEASE PREVENTION AND RECOMMENDATIONS		
1.	Stroke and coronary disease (BP, cholesterol, weight, stress, aspirin - 81 mg./day)	
2.	Cancer (diet, vitamin C - 500 mg., E - 400 units)	
3.	Osteoporosis (exercise, calcium 1500 mg., vitamin D - 400 units, estrogen)	
4.	Viruses and colds (wash hands, vitamin C – 500-1000 mg., Echinacea, fluids, zinc)	
5.	Other	

OTHER RECOMMENDATIONS/REFERRALS

Follow- up		**Next physical**	

Eloise Prescott, L.Ac., M.Ac.

Name		Date			
		DOB		Age	

ADDITIONAL HISTORY DISCUSSED

PHYSICAL EXAM