

**LIBERTYVILLE ACUPUNCTURE**  
**737 N. MILWAUKEE AVE.**  
**LIBERTYVILLE, IL 60048**  
**847-796-0123**

<b>PATIENT INFORMATION</b>	<b>CONTACT INFORMATION</b>
Date _____ Name _____ Address _____ City State Zip _____ Age _____ Birthdate _____ Occupation _____ Company name _____ Primary physician _____ Physician phone number _____ How did you hear about us? _____ _____	Home phone _____ Work phone _____ Other/cell phone _____ Email _____  Another person we may contact if needed: Name _____ Relationship _____ Home phone _____ Work phone _____
<b>HEALTH HISTORY</b>	
What are your primary concerns for coming in for treatment? 1- _____ 2 - _____ 3 - _____  How is your sleep? _____ _____  How is your digestion? _____ _____  List medications or food supplements you are taking. _____ _____  List serious illnesses, accidents or surgeries. _____ _____ _____	<b>Have you ever had:</b> <b>No Yes</b> <input type="checkbox"/> <input type="checkbox"/> Bleeding/clotting disorder (ITP, etc.) <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> A pacemaker  <b>Have you ever been prescribed:</b> <b>No Yes</b> <input type="checkbox"/> <input type="checkbox"/> Blood thinners <input type="checkbox"/> <input type="checkbox"/> Immune-suppressing drugs  <b>Check symptoms you have or have had in the last year:</b> <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty in focusing <input type="checkbox"/> Excessive worry <input type="checkbox"/> Excessive anger <input type="checkbox"/> Excessive fear <input type="checkbox"/> Fatigue/tiredness <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of sleep/poor sleep <input type="checkbox"/> Loss or gain of weight <input type="checkbox"/> Nervousness/irritability <input type="checkbox"/> Overwhelmed by life  How long has it been since you had a complete medical exam? _____

Patient name \_\_\_\_\_

MAIN COMPLAINT

Please fill out the following if you are coming in for physical pain, discomfort or neuropathy. (No need to fill this out if you are coming in only for other symptoms such as insomnia).

Please describe your worst symptom and its location (i.e. "Low back pain on the right side, shooting down my leg" "Headache across my forehead," "Tightness in my left neck and shoulder" etc. Also when it is worst (i.e. "Worst when standing," "Worst when driving," "Worst when I first get out of bed in the morning") and any additional comments.

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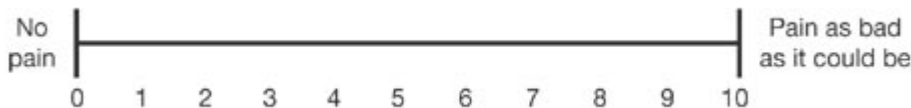
What is your pain/discomfort AT ITS WORST? (please put a mark on the horizontal line)



What is your pain/discomfort RIGHT NOW?



What is your pain/discomfort ON AVERAGE?



Please name any activities you have had to curtail or that have become difficult due to this pain/discomfort:

1. \_\_\_\_\_

2. \_\_\_\_\_

Please describe any additional complaints:

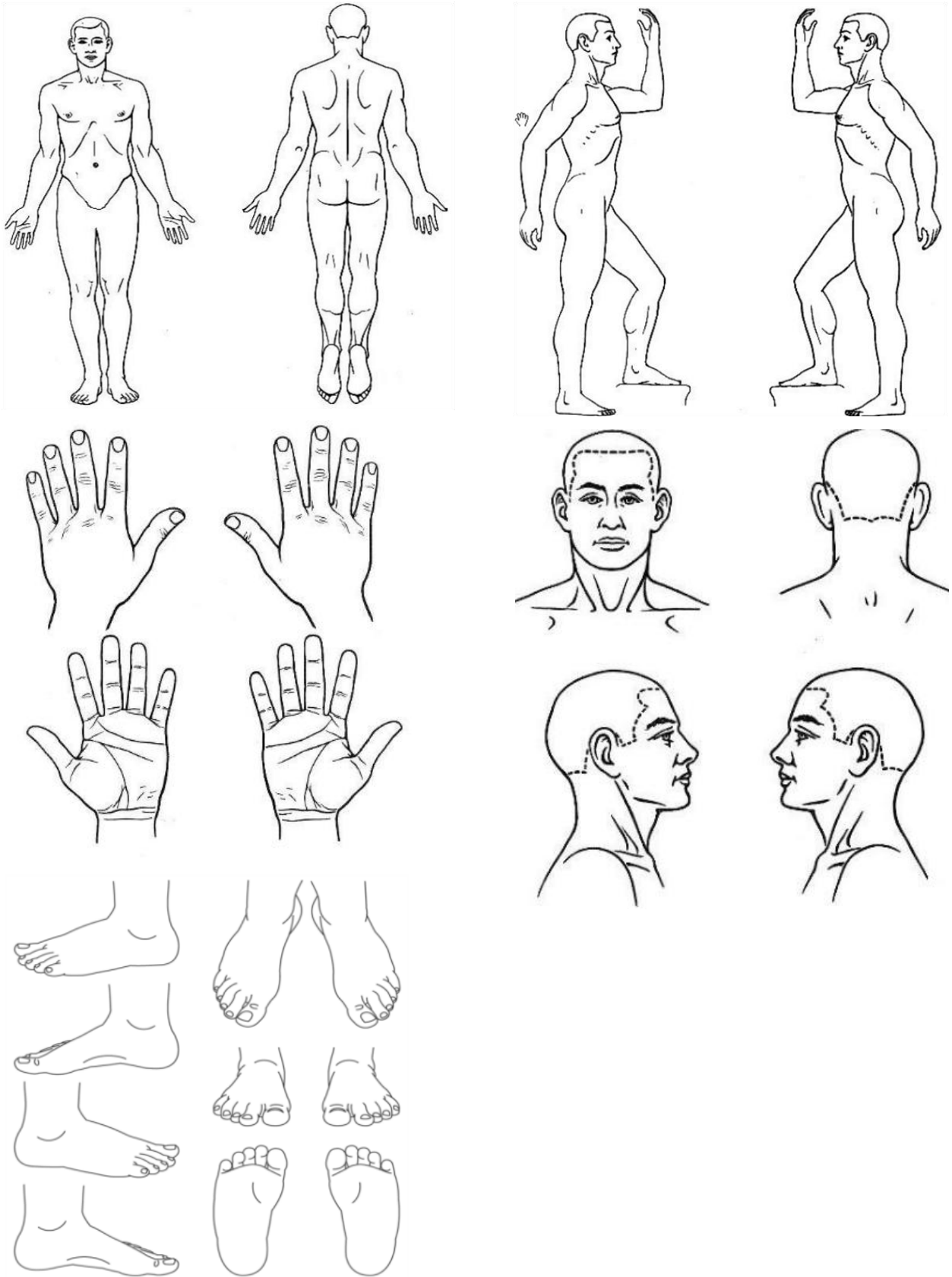
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Please mark wherever you have pain or discomfort



## CONSENT FOR ACUPUNCTURE

I understand that Libertyville Acupuncture does not provide primary care medicine, and that I am responsible to seek primary health care from a qualified medical doctor.

Acupuncture is a safe method of treatment, but may have side effects including slight pain or discomfort at the insertion site, bruising, and rarely temporary dizziness or faintness. Unusual risks of acupuncture include infection, although this clinic uses sterile disposable single use needles, maintains a clean and safe environment, and adheres to the principles of clean technique

I state that I do not have the following conditions:

- Pregnancy
- Bleeding disorders
- Local infections
- Use of anticoagulants (blood thinners)
- Pacemaker

If I do have any of the above, I have listed them here \_\_\_\_\_

I do not have any of the above \_\_\_\_\_

I give my consent for acupuncture treatment. I understand there is no guarantee that this treatment will cure or resolve the condition(s) for which I seek treatment. I understand that Libertyville Acupuncture cannot act as my primary care physician.

Signature of patient (legal guardian if under 18) \_\_\_\_\_

Date \_\_\_\_\_

### **Please check one of the lines below:**

Okay to share information with my physician

Please do not share my information with my physician.

### **CANCELLATION POLICY**

In the event I cannot keep an appointment I agree to give a minimum of 24 hours notice. I understand there is a \$40.00 charge for missed appointments not cancelled at least 24 hours in advance. This will be charged to your card if one is on file, or at your next appointment. There is no charge for cancellations due to unsafe weather conditions such as winter storms, or if you are too ill to come in.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_