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

PATIENT INFORMATION

Date_____

Name_____

Address_____

City State Zip_____

Age_____ Birthdate _____

Occupation _____

Company name _____

Primary physician _____

Physician phone number_____

How did you hear about us?_____

_____

CONTACT INFORMATION

Home phone _____

Work phone _____

Other/cell phone _____

Email _____

Another person we may contact if needed:

Name _____

Relationship_____

Home phone _____

Work phone_____

HEALTH HISTORY

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.

_____

_____

_____

Have you ever had:

No	Yes	
□	□	Bleeding/clotting disorder (ITP, etc.)
□	□	Seizures or epilepsy
□	□	Diabetes
□	□	A pacemaker

Have you ever been prescribed:

No	Yes	
□	□	Blood thinners
□	□	Immune-suppressing drugs

Check symptoms you have or have had in the last year:

- □ Depression
- □ Difficulty in focusing
- □ Excessive worry
- □ Excessive anger
- □ Excessive fear
- □ Fatigue/tiredness
- □ Headaches
- □ Loss of sleep/poor sleep
- □ Loss or gain of weight
- □ Nervousness/irritability
- □ 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.

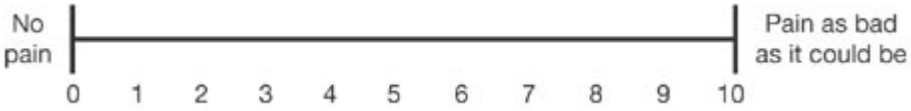
_____

_____

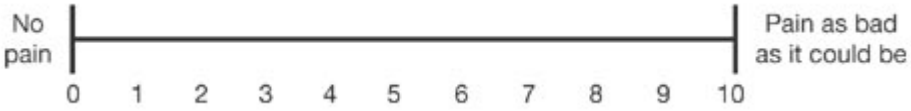
_____

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:

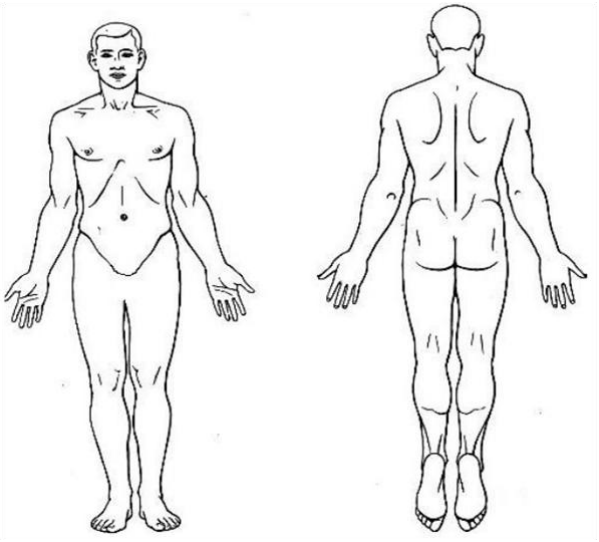
_____

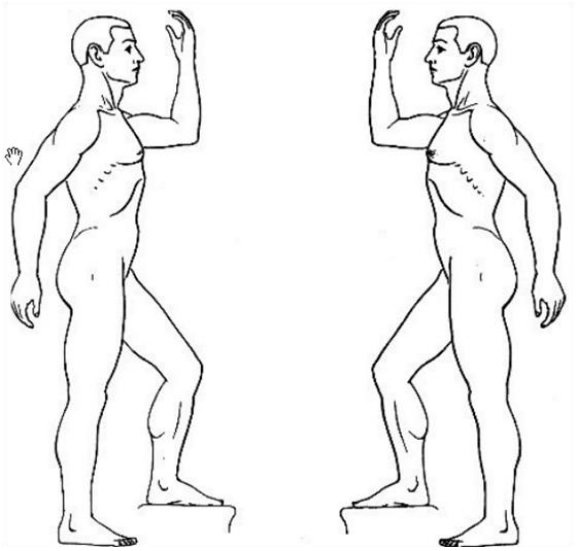
_____

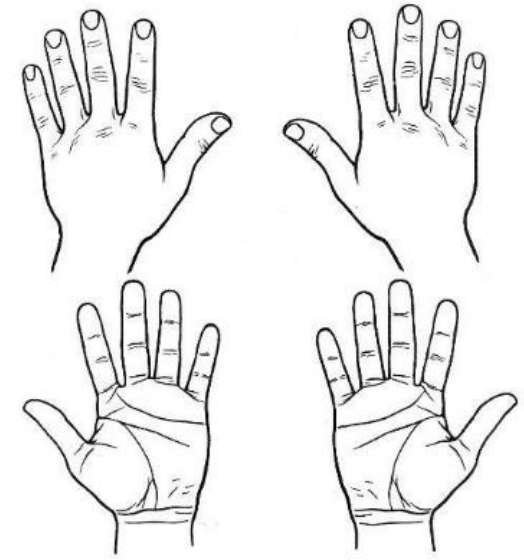
_____

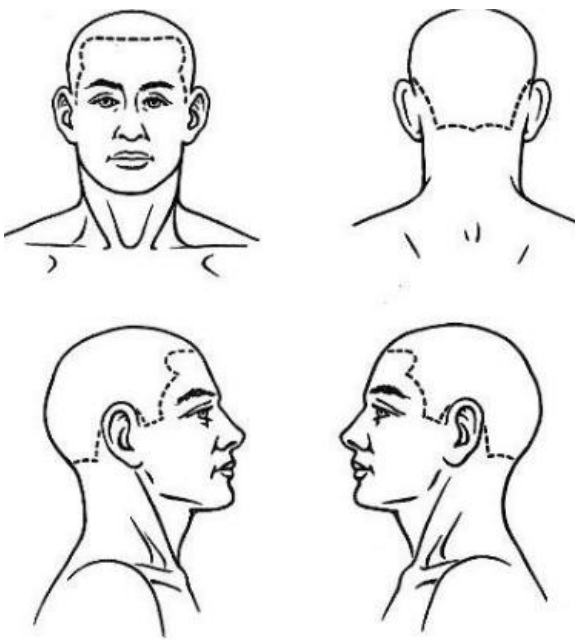
_____

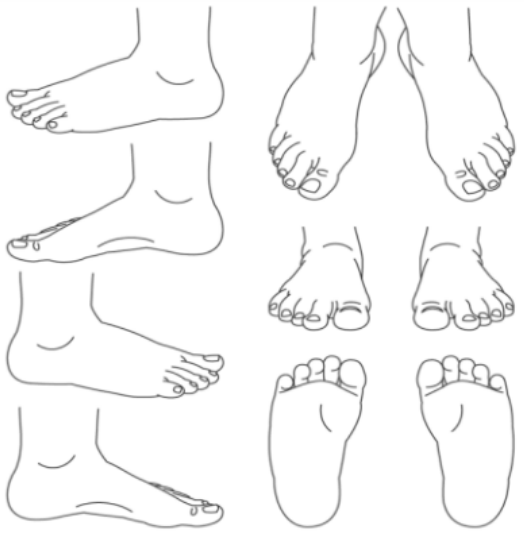
Please mark wherever you have pain or discomfort











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, bleeding, 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 understand that for patients with low back or hip pain, treatment may involve needling into the buttocks. I understand that if this is indicated, the acupuncturist will ask my permission. I understand that I can decline or withdraw permission at any time. I understand that I can stop the session at any time.

I state that I do not have the following conditions:

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

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_____