LUBOVICH CHIROPRACTIC, P. A. 10880 175th Ct. W. Suite 120 • Lakeville, MN 55044 • 952-898-4900

Chart #_____

ACUPUNCTURE INFORMATION

Last Name _____ Legal First _____ Middle Initial_____

Sex: ___M___F Birthdate:____/____/____ Single___ Married___ Widowed___ Divorced___ Separated___

Home Phone#:_____ Cell#:_____

Can we leave a message? ___Y___N Email:_____

Address:_____

street city state zip

Emergency Contact Name:_____ Relationship:_____

Phone#:_____

Have you been treated with Traditional Chinese Medicine and/or acupuncture in the past? Yes No

Please list the health concerns/conditions in order of importance:

1)_____

How/when did this begin?_____

How does this condition affect you?_____

Indicate the severity of the condition: 1 2 3 4 5 6 7 8 9 10
No symptoms Worst symptoms

2)_____

How/when did this begin?_____

How does this condition affect you?_____

Indicate the severity of the condition: 1 2 3 4 5 6 7 8 9 10
No symptoms Worst symptoms

List any therapies you are using or have used for the listed conditions:_____

_____

Have you been evaluated by a medical doctor for this condition? Yes No

If yes, what is the diagnosis?_____

Are you being seen by another health care provider for this condition? Yes No

Do you have a pacemaker or bleeding disorder? Yes No

Do you have any infectious diseases? Yes No If yes, please identify:_____

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Please list any medications (prescribed and over the counter), vitamins and supplements you are currently taking:

_____

_____

Family History

Please mark the following conditions for yourself and immediate family members:

	Self	Family		Self	Family
Cancer	_____	_____	IBS/Diverticulitis	_____	_____
Diabetes	_____	_____	Gastritis/Pancreatitis	_____	_____
Heart disease	_____	_____	Constipation	_____	_____
High blood pressure	_____	_____	Back pain	_____	_____
Stroke	_____	_____	Neck pain	_____	_____
Mental illness	_____	_____	Blood clots	_____	_____
Anxiety/Depression	_____	_____	Hypo/hyperglycemia	_____	_____
Allergies	_____	_____	AIDS/HIV	_____	_____
Anemia	_____	_____	Hepatitis	_____	_____
Arthritis	_____	_____	Tuberculosis	_____	_____
Asthma	_____	_____	Multiple Sclerosis	_____	_____
Headaches	_____	_____	Lupus	_____	_____
Migraines	_____	_____	Chronic fatigue	_____	_____
Pacemaker	_____	_____	Thyroid disease	_____	_____
Seizure disorder	_____	_____	Fibromyalgia	_____	_____

List any other medical conditions:_____

_____

List any food or drug allergies:_____

_____

List any surgeries:_____

_____

Women's Health:

Date of last menses _____/_____/_____ # of pregnancies:_____ # of births:_____

Please mark all symptoms you experience:

Feeling hot	_____	Feeling cold	_____	Night sweats	_____
Heavy periods	_____	Light periods	_____	Painful periods	_____
Irregular periods	_____	PMS	_____	Cramping	_____
Clotting	_____	Mid cycle spotting	_____	Yeast infections	_____

List any other symptoms you would like to address:_____

_____

I understand the above information and guarantee this form was completed correctly and to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided. I UNDERSTAND THAT FAILURE TO SHOW OR CANCELLING THE SAME DAY AS MY APPOINTMENT WILL RESULT IN A FEE. I hereby acknowledge and assume the potential risks associated with receiving treatment during the COVID-19 pandemic, including becoming infected with COVID-19 through this elective treatment, and give my express permission to you and the staff at your office to proceed with care.

_____

Patient signature (or patient representative, indicate relationship if signing for patient) Date

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ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT NAME:

ACUPUNCTURIST NAME: Jessa Wilson, L.Ac.

(Date)

PATIENT SIGNATURE X

(Or Patient Representative)

(Indicate relationship if signing for patient)