brookfield
acupuncture
and wellness center

3504 Grand Boulevard • Brookfield, IL 60513 p 708.387.2058 f 708.487.0436
www.BrookfieldAcupuncture.com • info@BrookfieldAcupuncture.com

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, low level laser therapy, herbal therapy, massage, Qi Gong, and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping, and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions. In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred, or carried out at this practice.

Patient Signature Date

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This is a **CONFIDENTIAL** questionnaire to help us determine the best treatment plan for you. If you have questions, please ask.

PERSONAL INFORMATION

Name_____Date_____
Home Address_____
City_____State_____Zip Code_____
Home Phone_____Work Phone_____
Email address:_____
Occupation_____Person Responsible for your account_____
Who should we thank for referring you to this office?_____

Sex: ____Male ____Female Height_____ Weight_____ Birthdate_____ Age_____
Marital Status: ____Married ____Single ____Divorced ____Widowed Number of children_____
Have you received acupuncture therapy before? ____Yes ____No
If yes, when? _____ With whom? _____

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer	❑	❑	_____	Diabetes	❑	❑	_____
Hepatitis	❑	❑	_____	Heart Disease	❑	❑	_____
High Blood Pressure	❑	❑	_____	Seizures	❑	❑	_____
Rheumatic Fever	❑	❑	_____	Emotional Disorders	❑	❑	_____
Infectious Diseases	❑	❑	_____	Tuberculosis	❑	❑	_____

Sexually transmitted Diseases: ❑ Gonorrhea ❑ Syphilis ❑ AIDS ❑ HPV ❑ Chlamydia ❑ Herpes Date_____

Medicine	Dosage	Reason	How long?	Prescribed by	Date of last check-up

Please indicate the use and frequency of the following:

	Yes	No	How much?		Yes	No	How much?
Coffee/black tea	❑	❑	_____	Tobacco	❑	❑	_____
Water Intake	❑	❑	_____	Soda	❑	❑	_____
Non-medical Drugs	❑	❑	_____	Alcohol	❑	❑	_____

What are the main health problems for which you are seeking treatment?

What forms of treatment have you sought?

List any other health problems you now have.

List any allergies, food sensitivities or food craving that you have.

List any accidents, surgeries, or hospitalizations (include date).

Lab results (please include copies).

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Significant	❑	❑	❑	❑	❑	
Other	❑	❑	❑	❑	❑	
Family	❑	❑	❑	❑	❑	
Diet	❑	❑	❑	❑	❑	
Sex	❑	❑	❑	❑	❑	
Self	❑	❑	❑	❑	❑	
Work	❑	❑	❑	❑	❑	
Exercise	❑	❑	❑	❑	❑	
Spirituality	❑	❑	❑	❑	❑	

FOR WOMEN

Age of 1st period (menarche)_____
Age of last period (menopause)_____
Number of days between periods_____
Number of days of flow_____
Color of flow_____
Clots? ❑ Yes ❑ No Color_____

Are you pregnant? ❑ Yes ❑ No # of pregnancies_____
# of live births____ # of live Abortions # of miscarriages____
Date of last: Gynecologic Exam_____ Pap Smear_____
Mammogram_____ Bone density Scan_____
Results_____
_____

Average number of pads you use per day: 1st day_____ 2nd day_____ 3rd day_____ 4th day_____ + days____
Have you been diagnosed with: ❑ Fibrocystic Breast ❑ Endometriosis ❑ Ovarian Cysts ❑ PID Other_____

Location of Pain (indicate before, during or after menses):

Cramping_____ Stabbing_____
Burning_____ Aching_____
Dull_____ Bloating_____
Consistent_____ Intermittent_____
Bearing down sensation_____

Other symptoms related to menses

❑ Discharge ❑ Vaginal dryness ❑ Headache
❑ Nausea ❑ Constipation ❑ Diarrhea
❑ Swollen breasts ❑ Mood swings ❑ Ravenous appetite
❑ Poor appetite ❑ Hot flashes ❑ Night sweats

FOR MEN

Date of last prostate check up_____ PSA result_____ Manual prostate exam result_____
Lab results_____
Frequency of urinations: daytime_____ nighttime_____ Color of urine: ❑ clear ❑ murky Odor:_____

Symptoms related to prostate

❑ prostate problems ❑ delayed stream ❑ dribbling ❑ Incontinence ❑ Impotence
❑ rectal dysfunction ❑ increased libido ❑ decreased libido ❑ premature ejaculation Other_____
❑ back pain ❑ groin pain ❑ testicular pain ❑ retention of urine _____

SYMPTOM SURVEY (FOR EVERYONE)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

blank (___) = never experience check mark (✓) = sometimes experience plus sign (+) = frequently experience

___lack of appetite
___excessive appetite
___loose stool or diarrhea
___digestive problems, indigestion
___vomiting
___belching, burping
___heartburn/reflux
___feeling of retention of food in the stomach
___tendency to become obsessive in work, relationships...
_____
___insomnia, difficulty sleeping
___heart palpitations
___cold hands and feet

___nightmares
___mentally restless
___laughing for no apparent reason
___agina pains
___abdominal pain
___chest pain
___sciatic pain
___headaches
___pain or coldness in the genital area
_____
___cough
___shortness of breath
___decreased sense of smell
___nasal problems
___skin problems
___feeling of claustrophobia

___bronchitis
___colitis or diverticulitis
___constipation
___hemorroids
___recent use of antibiotics
_____
___eye problems
___jaundice (yellowish eyes or skin)
___difficulty digesting oily foods
___gall stones
___light colored stool
___soft or brittle nails
___easily angered or agitated
___difficulty in making plans or decisions

___spasms or twitching of muscles
_____
___low back pain
___knee problems
___hearing impairment
___ear ringing
___kidney stones
___decreased sex drive
___hair loss
___urinary problems
_____
___fatigue
___edema
___blood in stool
___black tarry stool
___easily bruised
___difficult to stop bleeding

___asthma
___tendency to catch colds easily
___intolerance to weather changes
___allergies
___hay fever
___dizziness
___tendency to faint easily
___high cholesteral levels
___sudden weight loss