Jeanette Shuler, L.Ac.
Patient Intake Form

The Wellness Studio - Lincoln Park
1731 N. Marcey St., Suite 530, Chicago IL 60614

Last Name: _____ First Name: _____

Name you prefer to be called:_____

Date of Birth: ____/____/_____ Sex: M F SSN:_____-_____-_____

Marital Status: Employment status: Professional Title:_____
Single Married Other Employed Unemployed Student

Address:_____

City:_____ State: _____ Zip: _____

Home Phone:_____ Cell Phone:_____

Email: _____

Employer: _____

Emergency contact info:_____ Relationship:_____

Emergency contact Phone: _____

Who may we thank for referring you? _____

Authorization: I certify that all questions have been accurately answered to the best of my knowledge. I authorize the practitioner to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such a chiropractic and/or acupuncture care to third party payers and/or health practitioners. I authorized and request my insurance company to pay directly to the acupuncturist group insurance benefits otherwise payable to the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I agree to the **cancellation policy**: 24 hour notice or I will be charged $35.

X_____ Date:_____
Signature of patient

Please fill out the following form in as much detail as possible.

What is your chief complaint/present symptoms?

_____
_____
_____
_____
___

When did your present symptoms begin?

_____

How do you believe your problems began?

_____
_____
_____
_____

Have you ever had this condition or something similar before? **Yes / No**

- Previous episodes: **0 1-5 6-10 11+**
- Since the problem began: **Improving / unchanging / worsening**

What makes it better? (Circle all that apply)
Bending Sitting Rising Standing Walking Lying AM/PM When still On the move Other

_____

What makes it worse? (Circle all that apply)
Bending Sitting Rising Standing Walking Lying AM/PM When still On the move Other

_____

Have you been under the care of another health care provider for this condition? If so, when?

_____
_____

Have you been to any of the following healthcare practitioners: (circle all that apply)
Chiropractor Acupuncture Massage Reflexology

What activities do you do most during the day:
Sitting at desk Driving Walking Standing Lifting

Other

_____
_____

Is there any activity that you are not able to do as a result of your current symptom?
Yes / No

_____
_____

Does coughing, sneezing, or straining increase your pain? **Yes / No**

Bladder: **Normal / Abnormal**
Bowel: **Normal / Abnormal**
Disturbed sleep: **Yes / No**

Patient signature:
_____

Do you have any other health concerns?
_____
_____
_____

Allergies:
_____
_____

Have you ever been in any accidents (ie. Auto, falls from stairs or ladders), that may be relevant?
_____
_____
_____
_____

What surgeries have you had? _____
Year_____

_____
Year_____

_____
Year_____

Are you pregnant? _____ If yes, how far along? _____

If yes, what is your due date? _____

What medications are you taking? (including aspirin, etc)
_____
_____
_____

What vitamins and supplements do you take?
_____
_____
_____

Do you have an X-ray or MRI that relates to your current conditions? **Yes / No**

Habits: (please check):

Cigarettes _____ _ Quantity: _____

Alcohol _____ _ Quantity: _____

Coffee _____ Quantity: _____

Pop _____ Quantity: _____

Tea _____ Quantity: _____

Water _____ Quantity: _____

Do you exercise? How often? What activities?
_____
_____
_____

Have you lost or gained weight in the past year? How much?
_____
_____
_____

How do you characterize your stress levels? **High / Medium / Low**

Do you have a family history of:
(Please check **M** for mother, **F** for father, **S** for sibling, or **G** for grandparent)

_____High Blood Pressure _____Thyroid Disease _____Stroke _____Cancer
_____Heart Disease _____Headaches _____Back pain
_____Osteoporosis

_____Depression _____Arthritis _____Diabetes
_____Autoimmune

Patient signature:

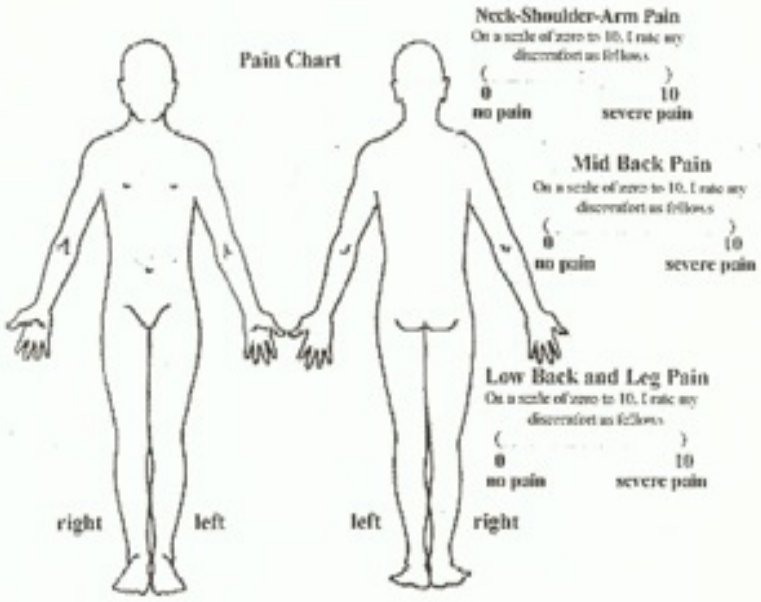
_____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	OOOOO	xxxxx	*****	/////
- - - - -	OOOOO	xxxxx	*****	/////
- - - - -	OOOOO	xxxxx	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.



Date: _____ Signature: _____

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Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	OOOOO	XXXXX	*****	/ / / / /
- - - - -	OOOOO	XXXXX	*****	/ / / / /
- - - - -	OOOOO	XXXXX	*****	/ / / / /

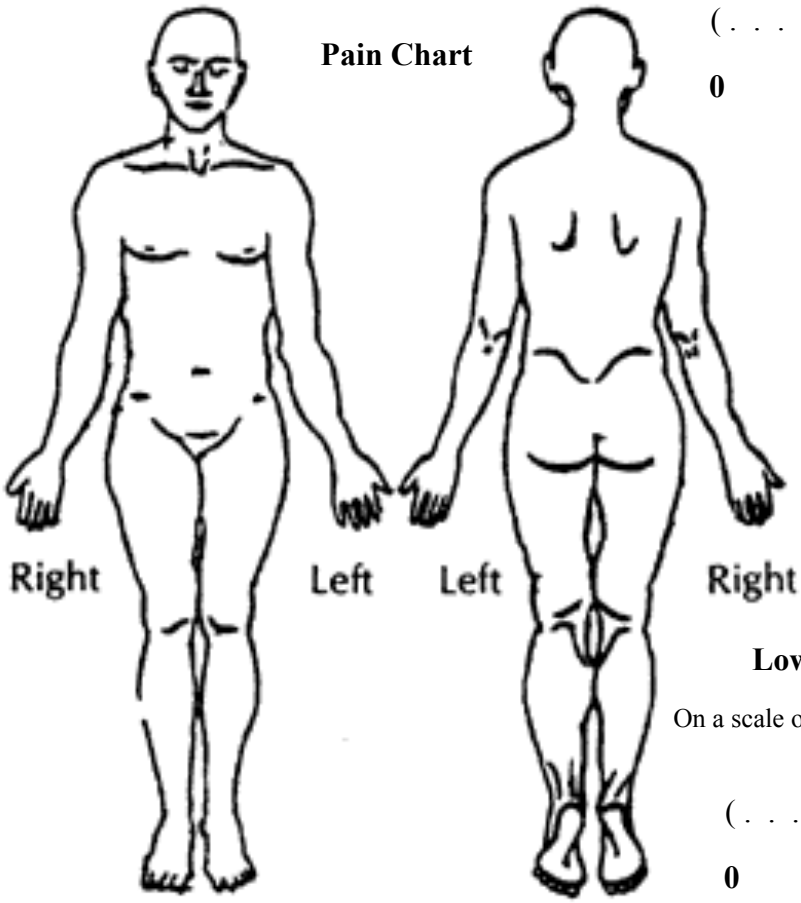
Neck-Shoulder-Arm Pain

On a scale of zero to 10, I rate my discomfort as follows

(. . . . .)

0 **10**

Pain Chart



Mid Back Pain

On a scale of zero to 10, I rate my discomfort as follows

(. . . . .)

0 **10**

Low Back and Leg Pain

On a scale of zero to 10, I rate my discomfort as follows

(. . . . .)

0 **10**

Date: _____ Signature: -

_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 named 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, Tiu-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 be 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 have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 results are not guaranteed.

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.

By voluntarily signing below, I show 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 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 SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE