geneva
acupuncture
& bodyworks

501 W State St, Suite 204
Geneva, IL 60134
(331) 248-0657
GenevaAcupuncture.com

PATIENT INFORMATION

Gender: M F

Name: _____ Marital Status: S M D W Partner
Last First MI

Home Address:_____ Cell Phone: ( ) _____

City, State, Zip:_____ Home Phone: ( ) _____

Email:_____ Birthdate: _____/_____/_____ Age: _____

INSURED INFORMATION *(only fill out this section if patient is different from the insured)*

Name: _____ Cell Phone: ( ) _____
Last First

Home Address:_____ Home Phone: ( ) _____

City, State, Zip:_____

Birthdate: _____/_____/_____ Relationship: Spouse Partner Parent Child Dependent

How did you hear about us? _____

HEALTH HISTORY *Check **all that apply**.*

- ❑ AIDS / HIV
- ❑ Alcoholism
- ❑ Allergies
- ❑ ALS (Lou Gerhig's)
- ❑ Alzheimer's
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Cancer *(type)*:
- ❑ Colitis / Crohn's / IBS
- ❑ COPD
- ❑ Depression
- ❑ Diabetes
- ❑ Drug Abuse
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herpes / Shingles
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Multiple Sclerosis
- ❑ Osteoporosis
- ❑ Parkinson's
- ❑ Pneumonia
- ❑ Sickle Cell Anemia
- ❑ Stroke
- ❑ Thyroid / Goiter
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Other:

Devices Currently Used

- ❑ Joint Replacement
- ❑ Implants of any kind
- ❑ Pacemaker

ALLERGIES:

_____

_____

PRIOR INJURIES & SURGERY:

_____

_____

CURRENT MEDICATIONS:

_____

_____

CURRENT NUTRITIONAL SUPPLEMENTS:

_____

_____

Symptom Questionnaire

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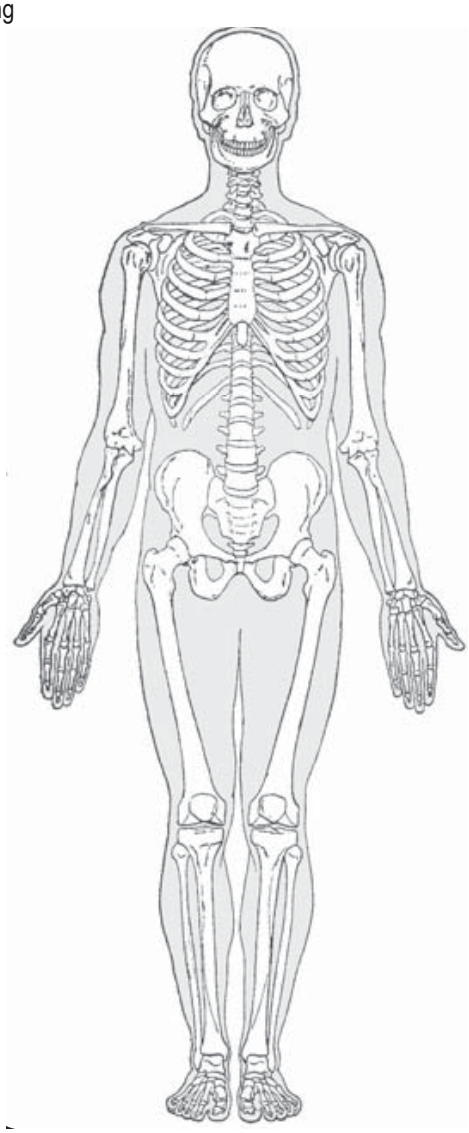
Please list your top 3 health concerns in order of importance.	**Mark an X** on the scale to indicate the severity of the condition.	How does the following affect: **Heat**	**Cold**	**Weather Change**	**Movement**
1)	Mild — Severe	Better / Worse / No Change	Better / Worse / No Change	Better / Worse / No Change	Better / Worse / No Change
2)	Mild — Severe	Better / Worse / No Change	Better / Worse / No Change	Better / Worse / No Change	Better / Worse / No Change
3)	Mild — Severe	Better / Worse / No Change	Better / Worse / No Change	Better / Worse / No Change	Better / Worse / No Change

PAIN

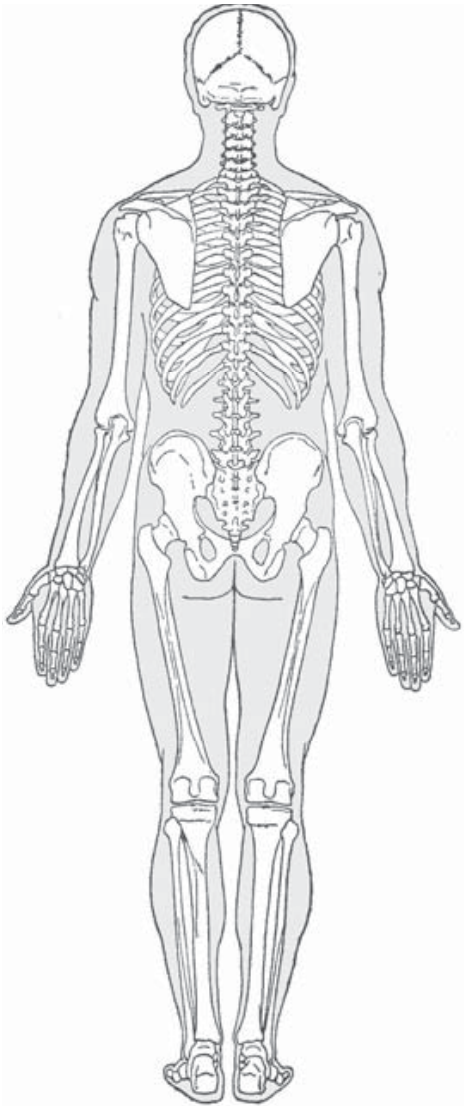
- ❑ Stabbing
- ❑ Aching / throbbing
- ❑ Burning
- ❑ Numbness / tingling

Mark symptomatic areas on the diagram below.
Feel free to make notes.

Right



Left



Right

Symptom Questionnaire

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*Please ☑ Check any of the following that you have experienced **within the last month**.*

Are You Pregnant or Trying?

❑ Yes ❑ No

General Symptoms

❑ Chills ❑ Fever ❑ Fatigue ❑ Sudden weight gain ❑ Sudden weight loss Gain weight: ❑ Easily ❑ Difficult

Temperature

❑ Cold hands or feet ❑ Chills ❑ Cold "in the bones" ❑ Numbness ❑ Thirst but no desire to drink ❑ Absence of thirst ❑ Prefer hot drinks
❑ Prefer cold drinks ❑ Excessive thirst ❑ Hot hands, feet, or chest ❑ Hot flashes ❑ Hot in afternoon ❑ Hot at night ❑ Night sweats

Moisture

❑ Dry skin ❑ Dry hair ❑ Dry eyes ❑ Dry, brittle nails ❑ Dry mouth ❑ Dry throat ❑ Dry lips ❑ Dry nose ❑ Nose bleeds
❑ Dandruff ❑ Oily skin ❑ Oily hair ❑ Excessive perspiration ❑ No perspiration ❑ Hair loss ❑ Edema (upper body) ❑ Edema (lower body)
❑ Itching ❑ Rash ❑ Fungal infection ❑ Dermatologic cysts ❑ Acne – Pustular ❑ Acne – Cystic ❑ Herpes zoster ❑ Herpes genitalia

Digestion

❑ Bad breath ❑ Poor appetite ❑ Belching ❑ Nausea ❑ Vomiting ❑ Stomach sounds ❑ Hernia ❑ Gluten sensitive ❑ Indigestion
❑ Excessive fullness after meals ❑ Reflux (GERD)/Heartburn ❑ Excessive hunger ❑ Bloating/Distention ❑ Flatulence/Gas

Elimination

Number of BM's per day: _____ ❑ Blood in stool ❑ Loose stool ❑ Constipation ❑ Alternating constipation/diarrhea ❑ Tired after BM ❑ IBS
❑ Crohn's disease ❑ Colitis ❑ Morning diarrhea ❑ Difficult to pass stools ❑ Dry small stool ❑ Pain with BM ❑ Hemorrhoids ❑ Anal fissure
❑ Undigested food in stool ❑ Foul smelling stool ❑ Bloating or pain relieved with BM ❑ Burning sensation in anus ❑ Pain on left side under rib cage

Liver & Gallbladder

❑ History of gallbladder attacks or stones ❑ Pain between shoulder blades ❑ Pain under right side of rib cage ❑ Headache over eyes / temples
❑ Greasy or high-fat foods cause discomfort ❑ Light or clay colored stools ❑ Bags or dark circles under eye ❑ Gag easily ❑ Sensitive to smells
❑ Genital itch / yeast infections ❑ Bad breath / white tongue ❑ Metallic taste in mouth

Sleep & Energy

❑ Difficulty falling asleep ❑ Dream disturbed sleep ❑ Restless sleep ❑ Difficulty staying asleep ❑ Not rested upon waking
Number of times you wake to urinate: ____ Hours of sleep per night: ____ Typical time you wake in the middle of the night?: ____
❑ Sudden energy decline ❑ Need stimulants (e.g. caffeine) ❑ Shortness of breath ❑ Difficulty concentrating ❑ Fatigue after eating
❑ Wired/ungrounded feeling ❑ Heart palpitations ❑ Poor memory ❑ General lethargy/fatigue ❑ Sensation of heavy body/limbs
❑ High blood pressure ❑ Bruise/bleed easily ❑ Weakness in body/limbs ❑ Low blood pressure ❑ Crave sweets ❑ Crave Salt
❑ Shaky, jittery, irritable if meals are missed ❑ Dizziness when standing up quickly

Neurological

❑ Dizziness ❑ Vertigo ❑ Fainting ❑ Seizures ❑ Tics ❑ Tremors ❑ Recent clumsiness ❑ Weakness/loss of grip ❑ Headaches

EENT

❑ Poor vision ❑ Night blindness ❑ Dry eyes ❑ Sore/red eyes ❑ Itchy eyes ❑ Visual floaters (spots in visual field) ❑ Tinnitus (ringing in ears)
❑ Poor hearing ❑ Mouth sores ❑ Bleeding gums ❑ Painful gums ❑ Tongue sores ❑ Painful swallowing ❑ Sore throat ❑ Cough
❑ Hoarseness ❑ Phlegm: clear / yellow / green ❑ Nosebleeds ❑ Sinus pressure/congestion ❑ Nasal discharge: clear / yellow / green

Urinary

❑ Difficulty starting/stopping ❑ Urgency to urinate ❑ Decreased flow ❑ Frequent urination ❑ Dribbling ❑ Copious urination ❑ Incontinence
❑ Painful ❑ Kidney stones ❑ Burning sensation ❑ Blood in urine ❑ Cloudy urine ❑ Dark urine ❑ Light/straw colored urine ❑ UTIs

Serotonin

❑ Losing pleasure in hobbies and interests ❑ Overwhelmed with ideas to manage ❑ Feelings of inner rage (anger) ❑ Feelings of paranoia
❑ Losing enjoyment for your favorite foods ❑ Losing your enjoyment of friendships ❑ Difficulty falling into deep restful sleep
❑ Sad or down for no reason ❑ Feel like you are not enjoying life ❑ Feel you lack artistic appreciation ❑ Depressed in overcast weather

Dopamine

❑ Feelings of hopelessness ❑ Self-destructive thoughts ❑ Inability to handle stress ❑ Anger and aggression while under stress
❑ Not rested even after long hours of sleep ❑ Prefer to isolate yourself from others ❑ Lack of concern for family and friends ❑ Easily distracted from tasks
❑ Consume caffeine to stay alert ❑ Decreased libido ❑ Lose temper for minor reasons ❑ Have feelings of worthlessness

Gaba

❑ Anxious or panic for no reason ❑ Feelings of dread or impending doom ❑ Knots in your stomach ❑ Overwhelmed for no reason ❑ Disorganized
❑ Feelings of guilt about everyday decisions ❑ Mind feels restless ❑ Difficulty turning your mind off ❑ Increased worrying / obsessing

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Cycling Woman Hormone Assessment

Average length of cycle: ____ days
Average length of menses: ____ days

Liver Congestion

- ❑ Frustration or irritability
- ❑ Headaches with period or at ovulation
- ❑ Period sometimes early and sometimes late
- ❑ Feeling sick or flu-like with period
- ❑ Moderate or severe menstrual cramps
- ❑ Endometriosis or fibroids
- ❑ Breast tenderness anytime of cycle
- ❑ Acne throughout cycle
- ❑ Poor response to birth control

Estrogen Deficiency

- ❑ Headaches after period stops
- ❑ Feeling more emotional after period
- ❑ Minimal cervical fluid with ovulation
- ❑ Vaginal dryness or needing lubricants
- ❑ Smaller breasts and low body weight
- ❑ Consistently late or early ovulation
- ❑ Wrinkles & crows feet at before age 40
- ❑ Early signs of menopause
- ❑ Hot flashes or night sweats after period

Estrogen Excess

- ❑ Mood swings prior to ovulation
- ❑ Breast tenderness prior to ovulation
- ❑ Endometriosis or fibroids
- ❑ Ovulating consistently early
- ❑ Spotting for 3 or more days at end of period
- ❑ Cervical fluid more than 3 days at ovulation
- ❑ Heavy menstrual cycles
- ❑ Moderate cramping for 3 or more days
- ❑ Clotting with menstrual cycle

Progesterone Deficiency

- ❑ Headaches or migraines after ovulation
- ❑ From ovulation to period under 14 days
- ❑ Eye twitching after ovulation
- ❑ Unclear when ovulating
- ❑ Breast tenderness prior to period
- ❑ Spotting prior to period
- ❑ Hot flashes / night sweats prior to period
- ❑ Problems falling asleep prior to period
- ❑ Depression / mood swings after ovulation

Progesterone Excess

- ❑ Irritability relieved with period
- ❑ Poor response to birth control
- ❑ Ovulation to period more than 14 days
- ❑ Running on warmer side after ovulation
- ❑ Weight gain around the middle
- ❑ Severe anxiety at night after ovulation
- ❑ Severe insomnia after ovulation
- ❑ Increased appetite after ovulation
- ❑ Morning sickness without pregnancy

Testosterone Deficiency

- ❑ Depression or lack of motivation all cycle
- ❑ Vaginal weakness or pain with intercourse
- ❑ Low libido or sex drive
- ❑ Sagging breast tissue
- ❑ No desire for sex for physical activity
- ❑ Chronic low energy
- ❑ Muscle weakness after exercise
- ❑ General aches and pains
- ❑ Difficulty maintaining muscle tone

Testosterone Excess

- ❑ Hot tempered after period
- ❑ Polycystic Ovarian Syndrome
- ❑ Menstrual cycles over 60 days
- ❑ Thinning hair on head or pubic area
- ❑ Diabetes or insulin resistance
- ❑ Deeper voice or male characteristics
- ❑ History of ovarian cysts
- ❑ Excessive facial and abdominal hair
- ❑ Acne or oily skin worse after ovulation

Other

- ❑ Vaginal or yeast infections

Menopause Hormone Assessment

Age at last menses: ____
Age changes began: ____

Liver Congestion

- ❑ Frustration or irritability
- ❑ Chronic headaches or migraines
- ❑ High cholesterol
- ❑ High ALT/AST liver enzymes on blood test
- ❑ Adult acne
- ❑ Hot flashes or night sweats
- ❑ Metallic taste in mouth
- ❑ Difficulty loosing weight
- ❑ Poor response to hormone creams/pills

Estrogen Deficiency

- ❑ Hot flashes and night sweats
- ❑ Thin lips or vertical wrinkles above upper lip
- ❑ Vaginal dryness
- ❑ Dry skin or dry eyes
- ❑ Depression or mood disorders
- ❑ Foggy thinking
- ❑ Waking early
- ❑ Osteoporosis or osteopenia
- ❑ High blood pressure

Estrogen Excess

- ❑ Mood swings
- ❑ History of clotty or heavy periods
- ❑ Breast tenderness
- ❑ Fibrocystic breasts
- ❑ Uterine ablation or history of endometriosis
- ❑ Uterine fibroids
- ❑ Water retention
- ❑ Low thyroid function
- ❑ Breast, ovarian, cervical, uterine cancer

Progesterone Deficiency

- ❑ Anxiety or mental restlessness
- ❑ Headaches or migraines
- ❑ Less fullness in breasts
- ❑ Hot flashes or night sweats
- ❑ Depression or mood disorders
- ❑ Neurological symptoms
- ❑ Eye twitching
- ❑ Problems falling asleep
- ❑ Restless Sleep

Progesterone Excess

- ❑ Mood swings or irritability
- ❑ Poor response to progesterone creams
- ❑ Chronic yeast overgrowth
- ❑ Low thyroid function
- ❑ Weight gain around the middle
- ❑ Severe insomnia
- ❑ Increased appetite
- ❑ Feeling tired or napping often
- ❑ Osteoporosis or osteopenia

Testosterone Deficiency

- ❑ Depression or lack of motivation
- ❑ Memory lapses
- ❑ Sagging breast tissue
- ❑ Vaginal or pelvic floor weakness
- ❑ Low libido or sex drive
- ❑ Low energy during the day
- ❑ Muscle weakness
- ❑ General aches and pains
- ❑ Loss of muscle tone

Testosterone Excess

- ❑ Mood swings or emotional outbursts
- ❑ Excessive facial hair
- ❑ Acne or oily skin
- ❑ Thinning hair on head or pubic area
- ❑ Diabetes or insulin resistance
- ❑ High blood pressure
- ❑ History of ovarian cysts
- ❑ High cholesterol
- ❑ Early menopause

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Office Policies

Appointments & Cancellation: Please be respectful of patients scheduled after you and be on time for your appointment. This helps us to be on time. Patients who arrive late and/or unprepared with the appropriate forms (this generally applies to new patients and repeat exams) may forfeit some of their appointment time which will still incur full charges. Please notify the office as soon as possible if you will be unable to keep your appointment. **Appointments missed and not cancelled at least 24 hours in advance will still incur full charges and cannot be billed to, nor reimbursed by insurance.**

Billing & Payment: Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We offer a complimentary benefits check to verify coverage; however, *the benefits quoted to us by your insurance company are not a guarantee of payment and you are ultimately responsible* for all charges. It is to be understood and agreed that any services rendered are charged to you directly.

Payment is due at the time services are rendered for deductibles, co-pays, co-insurance, or non-covered services. Please note, the following is considered not medically necessary by insurance and therefore a non-covered service:

- **Any treatment used for a purpose other than a musculoskeletal condition or sometimes nausea due to pregnancy.**
- **Any treatment for a musculoskeletal condition for the purpose of maintenance if further improvement has plateaued.**

The office accepts cash (please try to have exact change), personal check and charge (Visa, MC, & Discover). The fee for all checks returned for insufficient funds is $35.00. This fee will be automatically charged to your account if your check is returned from the bank. This fee is not covered by insurance. We will not accept checks for future payments if a check is returned unpaid, for any reason. All balances over 60 days must be paid immediately or they may be sent to collections which may include blemishes to your credit record.

Cell Phones: Please be respectful of others trying to relax. Cell phones are to be silenced before entering the office and phone calls made outside the office.

Product Sales: Due to the nature of heat sensitivity or the inability to divide herbs once combined, all product sales are final.

Assignment And Release: I assign directly to Geneva Acupuncture LLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. Furthermore, I authorize the release of my medical records to secure payment and/or to receive medical information pertaining to my case in the facility.

Permission to Communicate: I authorize and give permission to Geneva Acupuncture LLC to communicate with me by regular mail, email, phone calls to my home, cell phone or answering machine(s). I understand that communication will be in regards to appointments, clinical issues, clerical issues, and internal marketing. I understand that due diligence will be employed in being discrete about any clinical issues conveyed via any of the above modes of communication. I understand that I have the right to refuse certain types of communication by notifying Geneva Acupuncture LLC in writing.

HIPAA/PRIVACY: I understand a copy of this office's Notice of Privacy Practices is available at the front desk. I acknowledge receipt of a copy of this office's Notice of Privacy Practices, and my understanding and my agreement to its terms.

I hereby certify that I understand and agree to the policies set forth by Geneva Acupuncture LLC.

_____ _____

Signature of Patient *(or Legal Guardian if under 18)* **Date**

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CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic 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 have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti- inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

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 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 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. 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 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.

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. 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.

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 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.

I hereby certify that I understand the risks and consent to chiropractic and acupuncture treatment.

_____ _____

Signature of Patient *(or Legal Guardian if under 18)* **Date**