BALANCE CHICAGO

Acupuncture Intake Form

Name: _____ Date: _____

Age: _____ Gender: _____ Height: _____ Time: _____

Blood Pressure: _____ Occupation: _____

Main Complaint(s): _____

Date of Onset: _____ What caused it? _____

What makes it better? _____

What makes it worse? _____

Pain Quality: _____

What makes it better? _____

What makes it worse? _____

Energy Level: very low -1 2 3 4 5 6 7 8 9 10 - maximum

Consent For Traditional Mode of Treatment

I hereby authorize Julie Pleviak, the acupuncturist of Balance Chicago, to perform the following specific procedures.

Acupuncture - The insertion of special sterilized needles through the skin into the underlying tissues at specific points on the surface of the body.
Cupping - A technique to relieve symptoms with cups made of glass, bamboo, or other materials put on the skin with a vacuum created by using heat or other devices.
Gua Sha - A rubbing of an area of the body with a blunt, round instrument.
Moxa - The indirect burning of an acupoint using a stick, string, or ball moxa to relieve symptoms.
Tuina - An ancient massage technique used to treat a wide variety of common disharmonies.

I recognize the potential risks and benefits of this procedure as described below:
Potential Risks - Discomfort, pain, infection and blistering at the site of procedure, temporary discoloration of skin and even aggravation of existing symptoms.
Potential Benefits - Drugless relief of presenting symptoms and improved balance of bodily energies which may lead to prevention and elimination of presenting problems.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by LifeStyle Physical Therapy and Balance Center or any of its personnel regarding cure or improvement of my condition.
I hereby release Julie Pleviak from any and all liabilities which may occur in connection with the above procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in this procedure at any time.

Patient's Signature: _____ Date: _____

Appointment Policy

I, the patient, agree to be on time to receive the therapist's services for every appointment. I will make sure to see the front desk so that I can be checked in and my check in time will be recorded. I understand that reminder emails may be provided as a courtesy but I am still responsible for my appointments and any consequences associated with failing to keep or be on time to an appointment. I agree to *give at least 24 hours notice for any appointment I need to miss, cancel, or reschedule* or be subject to a $50 missed appointment fee.

I, _____ (name) have read and understand the above agreement and agree to comply fully with collections of any fee that I owe.

Patient's Signature: _____ Date: _____

Email Address (for email receipts): _____

Card on File Policy

Effective January 1, 2012, Balance Chicago has implemented a new card on file policy. Your information will be securely held to cover future charges with your notification before any transactions are processed. Signing this consent in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. I hereby authorize Balance Chicago to keep my card information on file for payment of any or all charges for medical services for which I am financially responsible and that remain unpaid after applying insurance payments and adjustments, if any. If my card information changes for any reason I will notify Balance Chicago. This consent shall remain in effect for one (1) year from the date set forth below or until I give written notification of its termination. *Please complete the credit card authorization form OR hand your card to the front desk person to swipe into the system*.

Credit Card Type: ☐ Visa ☐ Master Card ☐ Discover Card ☐ AMEX

Name on Card: _____ Card Number: _____ Exp: ____/____

Billing Street Address: _____ City, State, Zip: _____

To Be Completed by Acupuncturist

Headache, Dizziness _____

Temperature (Hot / Cold; Fever / Chills; Thirst): _____

Perspiration: _____

Appetite (Lack / Excess Appetite; Unusual Taste): _____

Digestion (Heartburn, Belching, Gas, Bloating): _____

Bowel Movements (Hard / Unformed; Dry / Watery): _____

Urination: _____

Eyes: _____ Nose: _____

Ears: _____ Mouth, Lips, Throat: _____

Chest / Abdomen: _____

Sleep: # of Hours _____ Dream-Disturbed: _____

Sexual Function: _____

Menstruation: Irregular: _____ Clots: _____ Breast Distention: _____ Length of Cycle: _____

Emotions: _____ Others: _____

Observation:

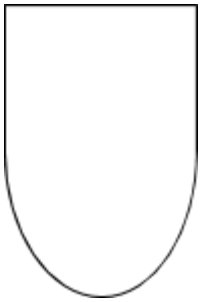
Facial Color: _____ Tongue: _____

Posture: _____ _____

Palpation: _____ Underside Veins _____

Pulse: R - _____ L - _____ Points: _____

Others: _____



DIAGNOSIS: _____

TX PRINCIPLE: _____

POINTS: _____

HERBS: _____

ACUPUNCTURIST SIGNATURE (Julie Pleviak): _____