Urbana**Acupuncture** llc

155-A Lincoln Square Mall, Urbana, IL- East Entrance
217-344-9118 - www.urbana-acu.com

Confidential Patient Information Date______________

Name____

Address______________________________________City___________State____Zip__________

DOB_______________ Preferred Pronoun__________Physician___________________________

Phone____

Email____

Who can we thank for telling you about us?___________________________

Financial Policy

Payment is made at the time of your visit. Please request receipts at the time of each payment.

We do **not** provide account statements of past activity.

We make acupuncture available to as many people as possible at the most affordable rates.
In consideration for others, please call us at least **24-hours in advance** to reschedule your appointments.
There is a **$15 late-cancellation or missed appointment fee.** Thank you for your cooperation.

Your Signature____

Informed Consent

Acupuncture involves the insertion of thin needles into particular points on the body. The purpose of this treatment is to prevent or reduce pain and to help your body function better.
There are some risks to treatment, including bruising of the skin and/or slight bleeding, weakness, fainting or aggravation of symptoms existing prior to acupuncture treatment. There is little to no risk of infection when all needles are sterile. Urbana Acupuncture only uses single-use, pre-sterilized, disposable needles.

We do not provide primary care; please see your medical doctor for those services & for routine check-ups.

If you are pregnant, have a stainless steel or nickel allergy, bleeding disorder, pacemaker, high blood pressure, seizure disorder, local infection or have been prescribed anticoagulant (blood thinning) medications, by signing below you state that you have informed your acupuncturist of such conditions.
With this knowledge, I voluntarily consent to the above procedures.

Print Name ____

Signature __________________________________ Date ____________

Current Condition

1. Tell us your **main concern**____

How much does it bother you? A little 1 ---------5----------10 A lot

How long has this been happening? _____________

How often does it happen? ______________________

2. Tell us your **second concern**____

How much does it bother you? A little 1 ---------5----------10 A lot

How long has this been happening? _____________

How often does it happen? ______________________

3. Tell us **other concerns** you would like us to know______________________________________

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Do you have problems with the following: Please circle those that apply.

Location Neck Shoulder Arm Elbow Wrist Hand Finger

Chest Back Ribs Abdomen Hip Groin Buttock

Leg Thigh Knee Calf Ankle Feet Toe

Head Sinus Nose Ear Throat Eye Jaw Mouth Teeth

Bone Muscle Spine Disc Joint Tendon Connective Tissue Skin

Description pain stiffness swelling weakness spasm tremors paralysis

hernia radiating pain numbness/tingling dizziness nausea

Body system

Pulse Palpitation Anemia Blood pressure Blood Sugar

Digestion Breathing Bowel Urination

Menstruation Fertility Hormone Sexual Energy / Function

Sleep Fatigue Sweating Hot Flashes Fever Chills

Stress Trauma Anxiety Depression Grief Anger

Worry Memory Concentration

Medical Conditions

Stroke HIV/AIDS Cancer Pneumonia Cardiac Problems Thyroid Disorder

Asthma Epilepsy Hepatitis Emphysema Tuberculosis Multiple Sclerosis Autoimmune Disorder