LUBOVICH CHIROPRACTIC, P. A. 10880 175th Ct. W. Suite 120 · Lakeville, MN 55044 · 952-898-4900

ACUPUNCTURE

PATIENT INFORMATION

Chart Number _____

Please print full legal name

Last _____ First _____ Middle Initial _____

Sex: ___M___F Birthdate: ___/___/___ Single___ Married___ Widowed___ Divorced___ Separated___

Contact Information: Can we leave a message? ___Y___N Email: _____

Home#: _____ Cell#: _____

Address: _____

street city state zip

Emergency Contact: _____ Phone#: _____

Have you been treated with Traditional Chinese Medicine and/or acupuncture in the past? Yes No

Please indicate the health concerns/conditions that you would like to treat in order of importance:

a) _____

How/when did this begin? _____

How does this condition affect you? _____

b) _____

How/when did this begin? _____

How does this condition affect you? _____

List any other therapies you are using or have used for the listed conditions: _____

_____

Have you been evaluated by a medical doctor for this condition? Yes No

If yes, what was the diagnosis? _____

Are you still being seen by another health care provider for this condition? Yes No

Do you smoke? Yes No Do you drink alcohol? Yes No Do you drink caffeinated drinks? Yes No

Do you have any infectious diseases? Yes No If yes, please identify: _____

Please list any medications (prescribed and over the counter), vitamins and supplements you are currently taking:

_____

_____

If applicable, please list any foods and drugs you are hypersensitive or allergic to:

_____

_____

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Chart Number _____

Please indicate the following for yourself and immediate family members.

Family History:	Self	Family Member	(please indicate: mother, father etc.)
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Stroke			
Mental Illness			
Anxiety/Depression			
Allergies			
Anemia			
Arthritis (osteo or rheumatoid)			
Asthma			
Headaches			
Migraines			
Chronic Fatigue			
IBS/Diverticulitis			
Gastritis/Pancreatitis			
Constipation			
Back pain			
Neck Pain			
Blood Clots			
Hypo/Hyperglycemia			
AIDS/HIV			
Hepatitis			
Tuberculosis			
Multiple Sclerosis			
Systemic Lupus			
Fibromyalgia			
Other:			

I understand the above information and guarantee this form was completed correctly and to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.

_____

Patient Signature Date

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Chart Number _____

FOR WOMEN ONLY:

Please check all that apply:

Vaginal dryness _____ How long?_____

Chronic vaginal yeast infections _____ How often?_____

Pelvic inflammatory disease _____

Sexually transmitted infections _____

Hysterectomy _____ Date and reason:_____

Uterine prolapse _____

Polycystic ovarian syndrome _____

Endometriosis _____

Fibroids _____

Mastitis _____

Abnormal PAP results _____ Reason for abnormal results:_____

Hot flashes _____ How often?_____

Night sweats _____ How often?_____

Mood changes with period _____

Irritability or anger _____

Cyclical headaches or migraines _____

Spotting in-between periods _____

Cramping with periods _____

Clotting with periods _____

Nausea _____

Fatigue _____

Dizziness _____

Breast changes _____

Digestive changes _____ Symptoms:_____

Difficult labor/delivery _____

Do you have any reason to believe you may be pregnant? Yes No Due date:_____

Do you have a regular menstrual cycle? Yes No If no, please explain:_____

Are you currently using birth control? Yes No If yes, type:_____

Are you trying to conceive? Yes No If yes, how long?_____

Number of pregnancies:_____ Number of miscarriages:_____ Number of children:_____ Number of abortions:_____

LUBOVICH CHIROPRACTIC P.A.

ROBERT C. LUBOVICH, D.C.

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Fax: (952) 898-7626

ACUPUNCTURE INFORMED CONSENT **CHART #:**_____

I understand that the treatment I receive at Lubovich Chiropractic P.A. is performed by a professional licensed acupuncturist certified by the Minnesota Board of Medicine and the National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM).

I have been informed that the policies and procedures at Lubovich Chiropractic P.A. meet standards for ensuring sterility set by the Centers for Disease Control and Prevention (CDC) and conform to the guidelines for Clean Needle Technique (CNT) established for acupuncturists by the National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM).

I understand that acupuncturists do not make Western medical (biomedical) diagnoses and that it is my responsibility to seek such diagnoses elsewhere if I have not already done so.

I hereby authorize Lubovich Chiropractic P.A., through their licensed acupuncturist to perform, diagnose and treat according to the professional standards of Oriental medicine and their own professional judgment. This authority shall extend to remedying any unforeseen conditions or reactions to treatment procedures. I understand that my treatment at Lubovich Chiropractic P.A. may include a variety of Oriental medical modalities, such as acupuncture, moxibustion, herbal therapies, cupping, electrical stimulation, magnet therapy, dermal friction (guasha), acupressure, dietary counseling, breathing techniques, and exercises based on Oriental medical principles.

I understand that there are possible unforeseen risks attendant to the performance of the procedures of Oriental medicine. I have been informed that possible side effects of Oriental medical treatment are rare and may include, but are not limited to, transient bruising, bleeding, skin irritation, mild pain in the treated area, muscle weakness and soreness, brief generalized fatigue or nausea, temporary worsening of some symptoms, and risk of infection. Herbal remedies may have side effects including, but not limited to, gastrointestinal disturbance. Moxibustion can cause burns.

I understand that no promises or guarantees can be made regarding the outcome of treatment and that reasonable efforts will be made to give me information so that I may make an educated decision regarding the duration and appropriateness of continuing care at Lubovich Chiropractic P.A. All of my questions have been answered to my satisfaction.

I understand and agree that I am ultimately responsible for the balance on my account and that all information provided is accurate to the best of my knowledge. I understand that all fees are payable at the time that service is received.

I **HAVE / HAVE NOT** (circle one) been examined by a licensed physician or other licensed health care provider with regard to my illness or injury. If yes, I have informed the acupuncturist of the diagnosis.

I **DO / DO NOT** (circle one) have a pacemaker or bleeding disorder.

_____ _____

Patient or Legal Guardian Signature Date

_____ _____

Witness Signature Date