Life Balance Acupuncture Clinic
Acupuncture, Herbal Medicine, Shiatsu
Liberty House, Suite 107
880 Liberty St. NE, Salem, OR 97301
phone 503.881.8996
lifebalanceacupuncture@gmail.com
www.acupuncturelifebalance.com

Patient Information

Name _____ Today's date _____

Date of Birth _____ Current age _____

Contact information/ Mailing address

Street address _____

City _____ State _____ Zip code _____

Phone _____ Email _____

Person to contact in an emergency _____
(please provide a name and a phone number)

Occupation _____

Do you have a current primary health care provider? _____

Address and phone _____

How did you hear about this clinic? _____

If patient is a minor, signature of parent or guardian _____

Health information

Major complaints _____

_____

_____

Medications/Supplements (please include dosage) _____

_____ _____

_____

_____ _____

_____ _____

Are you pregnant right now, or could you potentially pregnant? _____

Do you have any allergies to any foods, drugs, medications? Hypersensitivities?

_____

_____

_____

Injuries, accidents, major diseases, hospitalizations, surgeries, special studies or test (MRI, X-ray, cat-scans, blood work etc.)

_____

_____

_____

_____

Do you have a pacemaker or other artificial devices? Please specify.

_____

Do you have chronic or contagious diseases?

_____

Do you have a bleeding disorder? _____

Do you smoke, drink alcohol or take recreational drugs? Please specify the amount and regularity.

_____

Family history: Does anybody in your family (parents, grandparents) suffer of cancer, heart disease, high blood pressure, stroke, diabetes, lung diseases, allergies, mental-emotional disorders etc.?

_____

_____

_____

Fees and Policies

I,_____, the patient, understand that I am responsible for clarifying if my insurance carrier will pay for the treatment, what deductible I have to pay, and for all amounts my insurance carrier might deny to reimburse. Payments are due at time of treatment except when other agreements with Manuela Terlinden, Lac, are established.

Returned checks will carry a service charge of $ 25, and I agree hereby to pay this amount to Manuela Terlinden.

In case I am not able to keep an appointment, I agree to cancel it at least 12 hours prior. If I miss an appointment, or do not cancel it, I am responsible to pay a $ 35 fee.

Signature _____ Print _____ Date _____