Acupuncture Fertility
SPECIALISTS
Sacramento 916.486.0187 Roseville 916.789.1006 acupuncture4fertility.com

Dear New Patient,

Welcome to Acupuncture Fertility Specialists!

We hope you find your time with us as worthwhile and rewarding as hundreds of others before you. We strive to meet and exceed your expectations. Please take a moment to review some of the following information about us:

We are a mulit-practitioner clinc. All of our practitioners are trained in the field of Fertility Acupuncture and are fully qualified to care for your individual needs. We use a rotating schedule. All our fertility specialists share patient information and meet regularly to make sure that you are getting the most continious comprehensive care available. Due to the nature of the schedule you may be unable to see the same practitioner on a regular basis. We ask that you please be flexible with us and know that accomodating your care is our biggest priority.

Typical fertility care includes seeing you once a week through gestational week twelve, and once a month through the duration of your pregnancy. Acupuncture is a process, and each person's body responds to treatment differently. The average patient who gets pregnant through our clinic does so in five menstrual cycles. If you are with us for ten or more menstrual cycles with no pregnancy, we will discuss the possibility of a referral to a fertility clinic or some other form of medical care. If you need a break from care, please discuss this with your practioner so you can continue any nutritional supplements or dietary changes during this time, to avoid regression toward your pretreatment condition.

We will do our best to answer you questions about your fertility. We may occasionally refer you to a reproductive endrocrinologist for answers to your more complicated problems or for any information on prescription medications or surgical procedures. We work closely with RE's and OB/GYN's to achieve positive outcomes for our patients. If you are an IVF patient, we think the most critically important thing you can do to enhance your IVF success is the Day of Embryo Transfer protocol. You can read about this on our website at www.acupuncture4fertility.com.

We do not bill insurance. If you would like to get reimbursed by your insurance carrier for your treatments we can provide a super bill for your visits with a diagnosis code. We accept cash, check, Visa, or Mastercard at the time of service as payment.

Thank you for the opportunity to work with you. We look forward to helping you along your path to building a family.

Sincerely,

David D. Cherry, O.M.D., LAc & Associates

Acupuncture Fertility Specialists

Name (Last, First, M.I.):		M F	**DOB/ AGE:**
Address:			
Phone number:		**Alternate Phone Number:**	
Email Address:		**Occupation:**	
Emergency Contact:	**Relationship to Patient:**		**Phone number:**
Marital status:	Single Partnered Married Separated Divorced Widowed		
How did you hear about our clinic?		**Date of last physical exam:**	

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

PERSONAL HEALTH HISTORY
What are you seeking treatment for today?
What treatments have you tried for this issue previously?
Has your medical doctor given you a diagnosis for this issue? If so, what?
How long have you had this condition?
List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	

Have you had the following precedures? (Women only)					
HSG (hysterosalpingogram)	Yes	No	Hysteroscopoy	Yes	No
Laparoscopy	Yes	No	Intrauterine Insemination (IUI)	Yes	No
IVF	Yes	No			

Have you been tested for the following? (Women only)					
FSH	Yes	No	LH	Yes	No
Progesterone	Yes	No	Estrogen	Yes	No
AMH	Yes	No	TSH (Thyroid)	Yes	No
Prolactin	Yes	No			

Have you had the following levels checked?			
Vitamin D		Yes	No
B12		Yes	No

Major Illnesses		
Year	Reason	

Other Hospitalizations
Year

List any prescription medication or supplements you are currently taking		
Name		

Allergies to medications	Food Allergies	Environmental Allergies
Name		

FAMILY HEALTH HISTORY
List any Genetic Disorders/ Major Health Issues:

DIGESTION		
Do you have a poor appetite?	YES	NO
Do you feel tired and sluggish after a meal?	YES	NO
Is your energy lower after a meal?	YES	NO
Do you have urgent, loose, or foul smelling stools?	YES	NO
Do you experience heartburn or wake-up with a bitter taste in your mouth?	YES	NO
Do you have chronic hemorrhoids?	YES	NO
Do you have loose stools, abdominal pain, digestive problems?	YES	NO
Do you have early morning loose, urgent stools?	YES	NO
Do you feel bloated after eating?	YES	NO
Do you crave sweets?	YES	NO
Is your lower abdomen tender to the touch?	YES	NO
Can you feel any abnormal lumps in your lower abdomen?	YES	NO
Are you often sick, or do you have allergies?	YES	NO
Are you overweight?	YES	NO

ENERGY		
Is your libido low?	YES	NO
Are you lacking strength in your arms and legs?	YES	NO
Are you lacking in exercise?	YES	NO
Are you often fatigued?	YES	NO

Are you prone to feeling heavy or sluggish?	YES	NO
Are you prone to feeling heaviness or grogginess in the head?	YES	NO

MENTAL HEALTH/EMOTIONS

Is stress a major problem for you?	YES	NO
Are you prone to emotional depression?	YES	NO
Do you panic when stressed?	YES	NO
Do you have problems with eating or your appetite?	YES	NO
Do you cry frequently?	YES	NO
Are you prone to anger and/or rage?	YES	NO
Have you ever been to a counselor?	YES	NO
Do you seem low in spirit or lacking vitality?	YES	NO
Are you prone to agitation or extreme restlessness?	YES	NO
Do you have heart palpitations, especially when anxious?	YES	NO
Would you describe yourself as afraid a lot?	YES	NO
Are you prone to worry?	YES	NO

SLEEP

Do you have difficulty falling asleep at night?	YES	NO
Do you have difficulty staying asleep at night?	YES	NO
Do you have nightmares?	YES	NO
Do you wake up at night or early in the morning because you have to urinate?	YES	NO

WOMEN ONLY

Number of pregnancies _____ Number of live births _____		
Number of Premature Births _____ Miscarriages_____ Abortions _____		
Are you pregnant or breastfeeding?	YES	NO
Have you had a D&C _____ Hysterectomy _____ Cesarean _____		
Any urinary tract, bladder, or kidney infections within the last year?	YES	NO
Any problems with control of urination?	YES	NO
Any hot flashes or sweating at night?	YES	NO

Do you have vaginal irritation or rashes?	YES	NO
Do you have fibrocystic breasts or painful, unmovable breast lumps?	YES	NO
Are you prone to yeast infections and vaginal itching?	YES	NO
Do you have profuse vaginal discharge?	YES	NO
Do you have vaginal dryness?	YES	NO
Have you ever been diagnosed with uterine prolapse?	YES	NO
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	YES	NO
Experienced any recent breast tenderness, lumps, or nipple discharge?	YES	NO
Date of last pap and rectal exam: _____		

MENSTRUATION

Age at onset of menstruation:		
Date of last menstruatrion:		
Period every _____ days		
Do you have heavy periods?	YES	NO
Are your menses scanty and/or late?	YES	NO
Does your menstrual blood contain stringy tissue or mucus?	YES	NO
Does your menstrual blood contain clots?	YES	NO
Is your menstrual flow ever brown or black in color?	YES	NO
Is your menstrual blood thick and dark, or purplish in color?	YES	NO
Does your menstrual blood tend to be dull in color?	YES	NO
Is your menstruation thin, watery, profuse, or pinkish in color?	YES	NO
Do you ever spot a few days or more before your period comes?	YES	NO
Do you ever spot a few days after your period ends?	YES	NO
Do you break out with acne (especially premenstrually)?	YES	NO
Do you become bloated premenstrually?	YES	NO
Do you become irritable premenstrually?	YES	NO
Are you more tired around menstruation?	YES	NO
Do you have premenstrual breast distention or pain?	YES	NO
Do you have lower back pain premenstrually	YES	NO
Are your menses painful?	YES	NO
Do you experience any piercing or stabbing menstrual cramps?	YES	NO
Have you been diagnosed with endometriosis, uterine fibroids or polyps?	YES	NO
Do you feel your menstrual cramps in the external genital area?	YES	NO

Do you feel cramps during your period that respond to a heating pad?	YES	NO
Are your menstrual cramps accompanied by a bearing down sensation in your uterus?	YES	NO
Do you get dizzy or light headed around your period?	YES	NO

OVULATION

Do you feel mid-cycle pain around your ovaries?	YES	NO
Do you feel bloated or irritable around ovulation?	YES	NO
Are your breasts sensitive or sore at ovulation?	YES	NO
Are your nipples sensitive or sore at ovulation?	YES	NO
Do you have painful, unmovable breast lumps?	YES	NO
Are you more tired around ovulation?	YES	NO
Is your mid-cycle fertile with presence of cervical mucus?	YES	NO

All Patients:

Informed Consent and Permission to Treat

I, _____ have, by my signing of this form, give my permission to David Cherry, O.M.D., LAc. & Associates to treat me using acupuncture, electroacupuncture, and all related treatment modalities, within the laws and regulations governing the practice of acupuncture and Chinese herbal medicine in California. I am aware that acupuncture is a medical procedure, and as such has inherent risk of bodily harm associated with it. I am also aware that David Cherry, O.M.D., L.A.c. and his associates are highly skilled professionals with immaculate safety records, and I herewith give my permission for them to treat me. By signing this form, I am in no way giving up any rights I might have in any litigation in the event that such may occur.

_____ _____ (Patient Signature or Parent if patient is a minor) (Date)

24 Hour Cancellation Policy

If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be charged $40.00 upon your next visit. This policy is in place out of respect for our practitioners and our patients. Cancellations with less then 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule in that time slot.

By signing below, you acknowledge that you have read and understand the policy of Acupuncture Fertility Soeciallists as described above.

Thank you for your understanding and cooperation.

_____ _____

(Patient signature) (Date)

Patient Consent Form

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about the treatments, payment, or health care operations in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing.

Print name:_____ Signature:_____ Date:_____

Complaince Assurance Notification For Our Patients

To Our Valued Patients,
The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all or employees, managers, and doctors continually undergo training so that they may understand and comply with (HIPPA) with particular emphasis on the “Privacy Rule.” We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Complaince Program that we believe will help us prevent any inappropriate use of PHI.