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 the following information about us:

We are a multi-practitioner clinic. 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 continuous 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 accommodating 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 practitioner 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 endocrinologist 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

Today's Date:		
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:**
OBGYN Name:		
Number of pregnancies: _____ **Number of live births:** _____		
Number of premature births: _____ **Miscarriages:** _____ **Abortions:** _____		

Are you pregnant or breastfeeding?	**Yes**	**No**

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 procedures? (women only)					
HSG (hysteroslapingogram)	Yes	No	IVF	Yes	No
Laparoscopy	Yes	No	Intrauterine Insemination (IUI)	Yes	No
Hysteroscopy	Yes	No	D & C	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	Testosterone	Yes	No

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

Major Illnesses	
Year	Reason

Other Hospitalizations	
Year	Reason

List any prescription medications and/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:

WOMEN ONLY		
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 tend to run hotter than those around you?	Yes	No
Do you tend to run colder than those around you?	Yes	No
Do you have fibrocystic breasts or painful, unmovable breast lumps?	Yes	No
Do you have vaginal irritation or rashes?	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
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 menstruation:		
Period every _____ days.		
What cycle day are you today?		
Do you have heavy periods?	Yes	No
Are your menses scanty and/or late?	Yes	No
Does your menstrual blood contain stringy tissue?	Yes	No
Does your menstrual blood contain 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, water, 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 premenstrual)?	Yes	No
Do you have premenstrual bloating?	Yes	No
Do you have premenstrual irritability?	Yes	No
Are you more tired around your menstruation?	Yes	No
Do you have premenstrual breast distention or pain?	Yes	No
Do you have lower back pain premenstrual?	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 around ovulation?	Yes	No
Do you feel 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
Are you more tired around ovulation?	Yes	No
Do you notice the presence of clear stretchy mucus mid-cycle?	Yes	No

DIGESTION		
Do you have a poor appetite?	Yes	No
Do you feel tired and sluggish after a meal?	Yes	No
Do you feel bloated after eating?	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 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

Alcohol and Nicotine	
How many alcoholic beverages do you have in a week?	
Do you use nicotine or have you in the past for an extended period of time?	

Alcohol and Nicotine	
Do you use any other substances	

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 grogginess in the head or clouded thinking?	Yes	No

Mental Health/ Emotions		
Is stress a major problem for you?	Yes	No
Are you prone to emotional depression?	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 to urinate?	Yes	No

Informed Consent to Receive Treatment and Care

You are always welcome to ask for more details if you wish. Contraindications (symptoms or conditions that make a particular treatment inadvisable) for acupuncture treatment and certain herbs include a history of bleeding disorder or current anticoagulation therapy, implanted pacemaker or prosthetic heart valve, and use of certain medications. It is important that you notify your practitioner if any of these apply to you (Please initial below).

_____ I understand that the diagnosis given to me confirms to the principles of Traditional Chinese Medicine (TCM), and in no way purports to replace allopathic medical evaluation, diagnosis or treatment.

_____ I have provided a full history and description of the complaints and health status which is complete and accurate. I understand the need for communication with all of my health care providers regarding my health status is ongoing and necessary.

_____ I understand that no guarantee has been made concerning the use and effects of Traditional Chinese Medicine (TCM). I understand that in some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is sustained.

_____ I understand that I may stop treatment at any time.

_____ I understand that while this document describes major risks of treatment, other side effects and risks may occur.

_____ **Acupuncture**: I understand that it is a technique using small, sterile, stainless steel needles inserted at specific points in the body, causing a positive response in order to correct various ailments. The location and the application of the needles and the depth of the needle insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief painful sensation, and that there is a slight possibility of minor swelling, bleeding, discoloration of the skin, hematoma, a bruise at the site of needling, or fainting. Momentary euphoria or light headedness may occur after treatment. Some very rare risks of acupuncture include spontaneous abortion, pneumothorax (air in the chest cavity that could cause a collapsed lung) and infection.

_____ **Moxibustion**: I understand that this is the application of indirect heat supplied by burning the herb Folium Artemesiae Vulgaris over a single acupuncture point or groups of points. This generally produces a sensation of relaxation. The area being treated may remain red and warm for several hours after treatment. In rare incidences, a minor burn may occur at the site of moxibustion.

_____ **Cupping**: I understand that this is the application of round vacuum cups over a large muscular area, such as the back, to enhance blood circulation to the designated area. This method may produce a deep redness, discoloration, and on rare occasions, a minor blister which may persist for up to a week. These marks may resolve on their own and are not indications of complications or injury.

_____ **Acupressure Massage**: I understand that I may be given acupressure massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiologic functions. I am aware that side effects that may result from this treatment include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

_____ **Herbs and Nutritional Supplements**: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction. to modify or prevent pain perception, and to normalize the body's physiologic functions. Herbs are used to facilitate the body's own restorative process. The herbs are usually taken in tea form or mixing powdered granules. I understand that I am not required to take these substances but must follow the direction for administration and dosage if I do decide to take them.

_____ I understand that recommended herbs are traditionally considered safe in the practice of TCM, although some may be toxic in large doses. I understand that some dietary supplements are inappropriate during pregnancy, may interact with medications or other supplements, may have side effects of their own, or may contain potentially harmful ingredients not listed on the label. I also understand that most supplements have not been tested on pregnant women, nursing mothers, or children. Potential risks include but are not limited to: allergic reactions, nausea, gas, stomachache, vomiting, headache, diarrhea, rash, hives, and tingling of the tongue. Some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin. I will immediately notify my practitioner if any unanticipated or unpleasant effects associated with herb or supplement treatment.

_____ I understand that it is not possible to anticipate and explain all risks and complications. I understand and agree that my practitioner will exercise judgment during the course of treatment which they feel at the time, based on the facts known to them, is in the best interest of me as a patient.

_____ I hereby state that I have read and understand this form, that I have been given the opportunity to ask questions, and that all questions have been answered in a satisfactory manner. I wish to proceed with TCM treatment. I understand that I am free to withdraw my consent to treatment at any time.

_____

Patient Name:

_____

Signature of Patient or person authorized to consent on behalf of patient:

_____

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 upon your next visit. This policy is in place out of respect for our practitioners and our patients. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute 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 Specialists 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 what we can to secure and protect that privacy. We strive to always take precautions to protect that 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 ti 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 you Personal Health Information (PHI). If you choose to give consent int his 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 previously signed consent.

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

Print name: _____ Signature_____ Date _____

Compliance 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 our employees, managers, and doctors continually undergo training so that we may understand and comply with (HIPAA) 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 Compliance Program that we believe will help us prevent any inappropriate use of PHI.