



FERTILITY PROGRAM

MUST BE COMPLETED AND SIGNED BY
THE PATIENT AND THEIR PRACTITIONER
PRIOR TO THERAPY

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT + CARE

I _____ hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future treats me while employed by, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office or clinic.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine, and nutritional counseling.

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases and dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection, and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy and will consult my prenatal doctor before consuming any. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then know, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY THE PATIENT:

Are you pregnant: Yes No Maybe Patient's Name: _____

Date: _____ Patient's Signature: _____

TO BE COMPLETED BY THE PATIENT'S REPRESENTATIVE, IF NECESSARY, I.E. IF THE PATIENT IS A MINOR OR IS PHYSICALLY OR LEGALLY INCAPACITATED:

Patient's Name: _____ Patient's Representative: _____

Relationship of Authority: _____ Patient's Signature: _____

Witness Name: _____ Witness's Signature: _____

Practitioner Name: _____ Practitioner Signature: _____

Date: _____

ADVICE TO CONSULT A PHYSICIAN

I, _____, affirm that I have been advised by the attending acupuncturist, to consult a physician regarding the condition or conditions for which I am seeking acupuncture treatment. By signing below, I acknowledge receipt of this document.

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY TO ENABLE A MORE COMPLETE ASSESSMENT OF YOUR CONDITION.

Date: _____ Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Daytime phone: _____

Home phone: _____ Cell phone: _____ E-mail address: _____

Gender: Female Male Birthdate: _____ Place of Birth: _____

Marital status: Single Married Divorced Widowed Other _____

Height: _____ Weight: _____ Profession: _____

How were you referred to exhalation: Friend Relative Seminar Internet Other

Who is your current Reproductive Endocrinologist? _____

Endocrinologist Address: _____

City: _____ State: _____ Zip: _____ Daytime phone: _____

ADVICE TO CONSULT A PHYSICIAN

I, _____, affirm that I have been advised by the attending acupuncturist, to consult a physician regarding the condition or conditions for which I am seeking acupuncture treatment. By signing below, I acknowledge receipt of this document.

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

MEDICAL HISTORY

PLEASE CHECK **ALL** THAT APPLY:

Engage in safe sex HIV risk: self / partner TB risk: self/partner Hepatitis: self/partner Blood transfusions

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Please describe in detail the main problem(s) you would like to address. Include the onset, progression, aggravating and alleviating factors. How does this condition affect your life? Please rank your problem on a scale of 1 to 10 (where 1 is mild and 10 is severe):

On a scale of 1 to 10, how is your energy level (1 being the worst and 10 being the best)? Do you experience an energy slump at any particular time of day?

Urination: Do you experience any frequency, urgency, burning, dribbling? Do you notice any abnormal coloration? Do you have a history of urinary tract infections or other urinary dysfunction?

Bowel movement: Are they regular, once a day, twice a day, every other day, etc.? Do you ever experience diarrhea, constipation, alternation of the two, etc.? Any history of large intestine problems?

Do you experience any sensations of heat or cold? Do you prefer warmth, lots of sweaters and blankets? Or are you comfortable wearing T-shirts during colder weather?

MEDICAL HISTORY (CONTINUED)

How is your appetite? Are you hungry only at mealtimes? Or, more or less often?

Do you have any abnormal thirst, dry mouth or throat?

Do you experience night sweats? Sweating upon slight exertion?

Please describe in general what you eat. Do you eat a lot of sweets or any other particular foods? Do you crave salty foods? Sweets?

Do you experience digestive difficulties? Do you experience any bloating, reflux, gas or ulcers?

Do you have any known heart problems? Do you experience heart palpitations or fluttering?

Do you have any respiratory problems such as asthma, etc.? Do you experience shortness of breath?

Do you have ringing in the ears, low or high-pitched? Stuffy sensation in the ears?

MEDICAL HISTORY (CONTINUED)

Do your eyes ever burn, itch or tear? Do they feel gritty or dry? Do you have floaters (spots) before your eyes?

Do you fall asleep easily or have initial insomnia? Do you wake up in the middle of the night and have difficulty falling asleep again? Do you wake up feeling rested? Do you have vivid dreams or nightmares? Do your dreams center around any particular themes and if so, what?

Do you have a propensity to catch colds or get sick frequently?

If you smoke, consume alcoholic or caffeinated beverages, and/or engage in any other recreational drugs, please describe frequency and amount.

Please list all herbs and supplements you are currently taking along with dosage.

MEDICAL CONDITIONS

Do you have a history of any of the following conditions?

German measles (Rubella)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prolonged dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glasses/contact lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other lung conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other heart conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastric/duodenal ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intestinal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding tendency	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL CONDITIONS (CONTINUED)

Do you have a history of any of the following conditions?

- | | | | |
|--------------------------|--|--------------------------|--|
| Problems with anesthesia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Uterine cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney stones | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney infection | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bladder infection | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other kidney disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other forms of arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatoid arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Paralysis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lupus erythematosus | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thrombophlebitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Neurological disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Breast tumor (benign) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Varicose veins | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ovarian cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other | <input type="checkbox"/> Yes <input type="checkbox"/> No |

PREVIOUS SURGERIES

Have you ever had surgery? Yes No

PROCEDURE	DATE	INDICATION	OUTCOME

GYNECOLOGICAL HISTORY

First day of your last period: _____ Are your periods regular? Yes No Age at first period: _____

of days between periods: _____ # of days of bleeding: _____ Amount of bleeding: Light Medium Heavy

Have you ever needed medication to bring on your period? Yes No

Pain with menstruation? Yes No

Degree of pain: Mild Moderate Severe

Pain relieved by over the counter medications? Yes No

Starts with the onset of bleeding? Yes No

Begins a few days prior to the onset of bleeding? Yes No

Persists more than 48 hours? Yes No

Do you have pain with ovulation? Yes No

Do you experience pain with sexual intercourse? Yes No

Pain is mostly on the exterior? Yes No

Pain is mostly internal (deep penetration)? Yes No

Do you experience painful ovulation? Yes No

Are you experiencing a vaginal discharge? Yes No

Associated with itching or burning? Yes No

Associated with an unusual odor? Yes No

DRUG ALLERGIES

Are you allergic to any medications that you know of? Yes No

MEDICATION	REACTION

PLEASE ANSWER THE FOLLOWING:

How often have you taken antibiotics?

	<5 TIMES	>5 TIMES
Infancy/Childhood		
Teen		
Adulthood		

How often have you taken oral steroids?

	<5 TIMES	>5 TIMES
Infancy/Childhood		
Teen		
Adulthood		

Your childhood experiences:

When your mother was pregnant with you, did she:	YES	NO	DON'T KNOW	COMMENT
smoke tobacco				
drink alcohol				
take estrogen				
Were you a full-term baby?				
A preemie				
Breast fed?				
Bottle fed?				
As a child did you eat a lot of sugar?				

Please add anything else you feel we should know:

List all major emotional events in your life and approximately when they occurred. Please include any emotional events, whether or not you think they are major, that occurred within 6 months of the onset of your chief complaint. If there was an event, but you do not want to disclose it, please indicate that and the approximate date.

SOCIAL HISTORY

Occupation: _____

Do you use tobacco? Yes No #packs/day _____

Do you use alcohol? Yes No #drinks/wk _____

Are you currently married? Yes No How long? ____ years

Have you been married before? Yes No

Problems conceiving in that relationship? Yes No

How frequently do you have intercourse? ____ per week/month

Do you need to use a lubricant? Yes No

FAMILY MEDICAL HISTORY

Is there a history of any of the following conditions in the family?

CONDITION	YES/NO	COMMENTS
Diabetes		
Heart disease		
High blood pressure		
Kidney disease		
Multiple births		
Mental retardation		
Birth defects		
Inherited diseases		
Rheumatoid arthritis		
Mental illness		
Cancer		
Allergies (ie, food, dust)		
Drug abuse		
Thyroid disease		
Lupus erythematosus		
Blood disorders		
Breast Cancer		
Ovarian Cancer		
Uterine Cancer		
Other Cancers		
Sickle Cell Disease		
Cystic Fibrosis		
Tay Sachs		
Thalassemia		
Other		
Other		
Other		

Signature: _____ Date: _____

MALE MEDICAL HISTORY

Occupation: _____

Have you initiated any pregnancies in the past? Yes No

Number of pregnancies? _____

Number with current partner? _____

When was the most recent pregnancy? _____

Have you been evaluated by an Urologist? Yes No

If yes, what was the diagnosis? _____

Have you ever had a semen analysis? Yes No

If yes, when? _____

Please provide the following results of the analysis: Count (Million cell/ml) _____

Motility (%) _____

Morphology (% normal forms) _____

Other _____

Are you allergic to any medications? Yes No

Medication: _____

Reaction: _____

Are you taking any medications? Yes No

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Do you use tobacco? Yes No # packs/day _____ Do you use alcohol? Yes No # drinks/week _____

Do you use a hot tub? Yes No # times/week _____

Have you ever had any of the following tests or procedures?

TEST	DATE	RESULT	COMMENTS
Blood Tests			
FSG			
LH			
Testosterone			
THS			
Anti-sperm antibiotics			
DQ Alpha			
Semen Tests			
Hamster egg penetration			
Fructose			
Semen culture			
Male Surgery			
Vasectomy			
Vasectomy reversal			
Testicular biopsy			
Varicocele ligation			
Hernia repair			
Undescended testicle			
Removal of testicle(s)			
Other			