LOTUS SPRING ACUPUNCTURE AND WELLNESS INC

PERSONAL INFORMATION

Name: _____ DOB: _____ Age: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Primary Phone: _____ Alt. Phone: _____

Email: _____ Occupation: _____ Employer: _____

In Case of Emergency, whom should we notify? _____ Number: _____

How did you hear about our office? _____

OB/GYN: _____ Number: _____

Reproductive Endocrinologist: _____ Number: _____

Midwife: _____ Number: _____

Have you been given a medical diagnosis for your condition? _____

Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Partnered

Spouse/Partner Name: _____ Age: _____ Occupation: _____

Has your Spouse/Partner been given a fertility related diagnosis? _____

Is your Spouse/Partner under the care of our clinic: ____ Yes ____ No Years trying to conceive: _____

Do you have biological children with your Spouse/Partner? ___ Yes ___ No

If Yes, how many: _____ Ages: _____

Do you have biological children with a previous Spouse/Partner? ___ Yes ___ No

If Yes, how many: _____ Ages: _____

MEDICAL INFORMATION

Height:_____ Weight: _____ How long have you been trying to get pregnant: _____

List the Fertility Drugs you have taken: _____

_____

Medications you use currently: _____

_____

List any non-prescription or recreational drugs you currently take (eg. Vitamins / Supplements): _____

_____

Have you been tested for Chlamydia? ___ Y ___ N Results: ___ Positive ___ Negative

History of Sexually Transmitted Disease (STD): _____

Menstrual Cycle:

Age menstruation began: _____

My periods are: ___ like clockwork ___ somewhat regular ___ erratic

If erratic: ___ shortest # of days ___ longest # of days

Number of days in a typical menstrual cycle: _____

Menstrual bleeding tends to be: ___ light ___ normal ___ heavy

Is there clotting with your period: ___ Y ___ N

Do you have spotting before / between periods: ___ Y ___ N

During ovulation, is your cervical mucus: ___ clear ___ stretchy ___ abundant

If not all three of the above, please describe: _____

On what cycle day do you typically ovulate: _____

Do you regularly experience PMS: ___ Y ___ N

If yes to above which symptoms do you experience: ___ breast tenderness ___ diarrhea ___ Acne

___ bloating ___ constipation ___ back pain ___ food cravings ___ dizziness ___fatigue

___ headaches / migraines ___ mood swings ___ pain with period

Number of:

_____ Pregnancies	_____ Cesarean Births	_____ Vaginal Births	_____ Abortions
_____ Miscarriages	_____ Ectopic(s)	_____ Failed IUIs	_____ Failed IVFs

Previous Gynecological Surgeries:

_____ Dilation & Curettage (D&C)	_____ Laparoscopy (uterine fibroids)
_____ Falloposcopy	_____ Myomectomy
_____ Hysterosalpingogram (HSG)	_____ Neosalpingostomy
_____ Hysteroscopy	_____ Tuboplasty
_____ Laparoscopy (endometriosis)	_____ Other: _____
_____ Laparoscopy (ovarian cysts)	

Previous Diagnostic Assessments: *Check any diagnosis received by your OB/GYN or Fertility Dr.*

___ Advanced Maternal Age ___ Amenorrhea ___ Anovulation

___ Anti-sperm Antibodies ___ Autoimmune Oopharitis ___ Cervical Stenosis

___ Elevated FSH _____ ___ Endometriosis (mild moderate severe)

___ Erratic Cycles ___ Fallopian Tube Blockage ___ Habitual Miscarriage

___ Hostile Cervical Mucus ___ Hyperprolactinemia ___ Luteal Phase Defect

___ Menorrhagia ___ Ovarian Cyst (single) ___ Ovarian Hyperstimulation Syndrome (OHSS)

___ Pelvic Inflammatory Disease (PID) ___ Phospholipid Antibodies ___ Polycystic Ovarian Syndrome (PCOS)

___ Premature Menopause ___ Premature Ovarian Failure (POF) ___ Resistant Ovarian Syndrome

___ Unexplained Infertility ___ Uterine Fibroids ___ Uterine Septum

___ Other(s): _____

GENERAL HEALTH INFORMATION

Regular exercise: ___ Yes ___ No **If yes, what forms of exercise?** _____

Major Health Complaints: Other than your primary reproductive concerns, please list any health concerns or complaints that you have in order of their significance.

_____ _____

_____ _____

_____ _____

_____ _____

Please explain how these conditions affect or impair your daily activities: _____

_____

_____

Describe your symptoms when they are at their worst: _____

_____

_____

Are there any other complaints or conditions that you would like us to know about? _____

_____

MEDICAL CONDITIONS AND HISTORY: check any conditions you currently have or have had in the past

___ Diabetes
___ Heart Disease
___ Asthma
___ Mental Illness
___ Kidney disease
___ Meningitis
___ Epilepsy
___ Paralysis
___ Lung disease
___ High Cholesterol
___ Allergies
___ Stroke
___ Pneumonia
___ Measles
___ HIV
___ High fever
___ Cancer
___ Chlamydia
___ Liver disease
___ Glaucoma
___ Vein condition
___ Tuberculosis
___ Mumps
___ Chicken Pox
___ Polio
___ Hepatitis
___ Migraines
___ Kidney disease
___ Rheumatic fever
___ Thyroid disorder
___ Emphysema
___ Bleeding/Hemorrhage
___ Nervous disorder
___ Auto Immune Disease
___ Hypertension
___ Mental Illness
___ Gonorrhea

Please check any of the following **symptoms** that currently pertain to you (if you have symptoms in the following categories, it indicates that you may have a problem with that organs function; this information will assist with our Chinese Medicine diagnosis).

___ Cold hands
___ Cold feet
___ Sweaty palms
___ Hot flashes
___ Hot body temperature
___ Cold body temperature
___ Afternoon flushing
___ Strong thirst
___ Profuse perspiration
___ Lack of perspiration
___ Night sweating
___ Perspire easily
___ Night time urination
___ Sweaty feet

Energy and Stamina (Lung and Kidney System)

___ Easily fatigued
___ Sweating
___ Lethargy
___ Shortness of breath
___ Prone to illness
___ Frequent colds/flu/ Sinus infections
___ Wheezing
___ Allergies

Blood Function (Liver, Heart and Spleen System)

___ Dizziness
___ Poor night vision
___ Floaters
___ Tingling in extremities
___ Difficulty concentrating
___ Weak or brittle nails
___ Itchy or Dry Skin
___ Poor memory
___ Fainting
___ Blurry Vision
___ Tinnitus

Heart Function

___ Manic moods ___ Heart palpitations ___ Forgetfulness ___ Tongue ulcers

___ Anxiety ___ Restless dreams ___ Hallucinations ___ Speech impediment

___ Insomnia ___ Mental restlessness ___ Depression ___ Severe shyness

___ Chest pain ___ Arrhythmia ___ High Blood Pressure ___ Low Blood Pressure

___ Hemophilia ___ Rapid Heart Beat ___ Heart Murmur ___ Mitral Valve Prolapse

Lung Function

___ Persistent cough ___ Chronic allergies ___ Dry or flaky skin ___ Headaches

___ Nosebleeds ___ Nasal dryness ___ Sneezing ___ Difficulty breathing

___ Sore throats ___ Sinus congestion ___ Cigarette smoking

Allergies to:

___ Mold ___ Cedar ___ Pet fur ___ Dust ___ Pollen

___ Oak ___ Hay ___ Environmentally sensitive

If you are a smoker, # of cigarettes per day: _____ How long have you been smoking: _____

If you are a smoker, do you want to quit? ___ Yes ___ No If yes, determination on scale 1 – 10 _____

10 being the greatest

Spleen Function

___ Low or weak appetite ___ Abdominal Bloating ___ Gurgling in intestines ___ Hemorrhoids

___ Abrupt weight gain ___ Gas ___ Fatigue following a meal ___ Hypoglycemia

___ Abrupt weight loss ___ Strong food cravings ___ Bruise easily ___ Indigestion

Stomach Function

___ Stomach ache ___ Bad breath ___ Stomach ulcer ___ Nausea

___ Acid reflux ___ Bleeding gums ___ Belching ___ Vomiting

___ Ravenous appetite ___ Heartburn ___ Hiccups ___ Mouth ulcers

Bowel Function and Elimination (Intestinal Function)

___ Loose stools ___ Constipation ___ IBS or Colitis ___ Crohn's disease

___ Diarrhea ___ Blood in stools ___ Small, hard, dry stools ___ Eating disorder

___ Incomplete stools ___ Mucous in stools ___ Less than 1 BM per day

Accumulated Dampness

___ Mental fog ___ Swollen hands ___ Edema in the legs ___ Swollen Feet

___ Mental sluggishness ___ Poor mental focus ___ Edema in abdomen ___ Chest congestion

___ Joint stiffness/ache ___ Heaviness of the head, limbs, or whole body ___ Symptoms worse in Rainy weather

Liver and Gall Bladder Function

___ Chest pain ___ Irritability ___ Depression ___ All over body tension

___ Chest tightness ___ Easily angered ___ Pain in ribcage ___ Heaviness in ribcage

___ Acne ___ Skin rashes ___ Headaches ___ Chronic neck tension

___ Muscle spasms ___ Convulsions ___ Migraines ___ Easily frustrated

___ Muscle cramps ___Seizures ___ Gall stones ___ Numbness / Tingling

___ Shoulder tension ___ Ringing in ears ___ Lump in throat ___ Alternating diarrhea and constipation

___ Eye pain / dryness ___ Easily overwhelmed by stressful circumstances

Eyes (Liver Function)

___ Itchy eyes ___ Grittiness ___ Bloodshot ___ Far sighted ___ Dry eyes

___ Poor night vision ___ Seeing spots ___ Astigmatism ___ Watery eyes ___ Glaucoma

___ Near sighted ___ Red and irritated

Kidney and Urinary Bladder Function

___ Weak knees ___ Hair loss ___ Knee soreness ___ Colder lower back

___ Weak bones ___ Cold knees ___ Hearing loss ___ Early graying of hair

___ Incontinence ___ Frequent cavities ___ Broken/loose teeth ___ Ringing in ears

___ Prostate problems ___ Low back pain ___ Quick to fear / fright

Urinary Function

___ Normal color ___ Reddish color ___ Small amount ___ Night-time urination

___ Dark Yellow ___ Cloudy ___ Large amount ___ UTI / Pain or burning

___ Clear color ___Strong odor ___ Very frequent ___ Hesitancy

___ Dribbling ___ Weak stream ___ Difficulty initiating the stream

Libido Function

___ Normal ___ High sex drive ___ DED ___ Diminished sex drive

___ Infertility ___ Painful ejaculation ___ Fatigue following sexual activity

FERTILITY STRESS ASSESSMENT

Managing stress effectively is an essential component of healthy reproduction. The more effectively stress is managed, the more your body and mind become relaxed, receptive and fertile.

Is your job stressful, or fast paced? ___ Yes ___ No

How would you rate your current stress level? (1 least, 10 highest) 1 2 3 4 5 6 7 8 9 10

In what areas of your life do you feel the most stressed?

___ Fertility process ___ Job / Career ___ Partner / Spouse relationship ___ Parents / Family

___ Financial ___ Friends ___ Other: _____

How does this stress impact your:

Health: _____

Thoughts about self: _____

Thoughts about others: _____

Feelings / Mood: _____

Actions: _____

How would you describe your current level of hopefulness towards attaining your fertility goals?

(1 least, 10 highest) 1 2 3 4 5 6 7 8 9 10

What are your main source(s) of support?

___ Spouse / Partner ___ Family ___ Friends ___ Workplace ___ Church

___ Support group ___ Therapist ___ God / Prayer ___Myself

What methods of relaxation and / or healing are you currently using:

___ Massage therapy ___ Physical exercise ___ Meditation ___ Prayer

___ Yoga ___ Guided imagery ___ Energy work ___ Other: _____

MEDICAL EVALUATION

I was evaluated by a physician, reproductive endocrinologist, or chiropractor for the condition(s) being treated within the last 12 months.

___ Yes ___ No

Permission to share medical information

Many of our patients are under the care of an OB/GYN, a Reproductive Endocrinologist, or a Fertility Specialist. In an effort to maximize your clinical results, we may want to contact your Doctor(s), and send them periodic updates about your case and your progress. Do you grant your permission for us to discuss the details of your case with your OB/GYN, Reproductive Endocrinologist and / or Fertility Specialist?

___ Yes ___ No

_____ _____

Patient Signature Date

Informed Consent to Oriental Medical Healthcare

I hereby request and consent to the performance of acupuncture treatments and other procedures with in the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, electrical stimulation, Tui-Na (Chinese massage), moxibustion, Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effect associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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, although some may be toxic in some doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that the results are not guaranteed.

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

By voluntarily signing below, I show that I have read or have had read to me the above consent to treatment. I have been told about the risks and benefits of acupuncture and other procedures and have had the opportunity to ask questions. 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.

I also understand that Lotus Spring Acupuncture and Wellness, Inc. requires a minimum of 24 hours notice for an appointment change or cancellation. A $70 service fee will be charged for any missed appointments.

_____	_____	_____
Patient name (please print)	Patient signature	Date

If under 18 years old

_____	_____	_____
Print name of patient representative	Relationship or authority of patient representative	Date

_____

Signature of patient representative