Anna Totzke, Registered Acupuncturist TouchStone Health
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ACUPUNCTURE: FEMALE FERTILITY INITIAL INTAKE FORM

Date:

Last Name:	First Name:

circle: Mr. Ms. Mrs. Dr.

Birth date: Age:	Phone (home):
Address:	Phone (work):
	Phone (cell):
Email:	Occupation:
Reason for Visit:	Family Physician Name:
	Family Physician Phone:

Please indicate with '**P**' (past) '**C**' (current) '**F**' (family) if any of the conditions below apply:

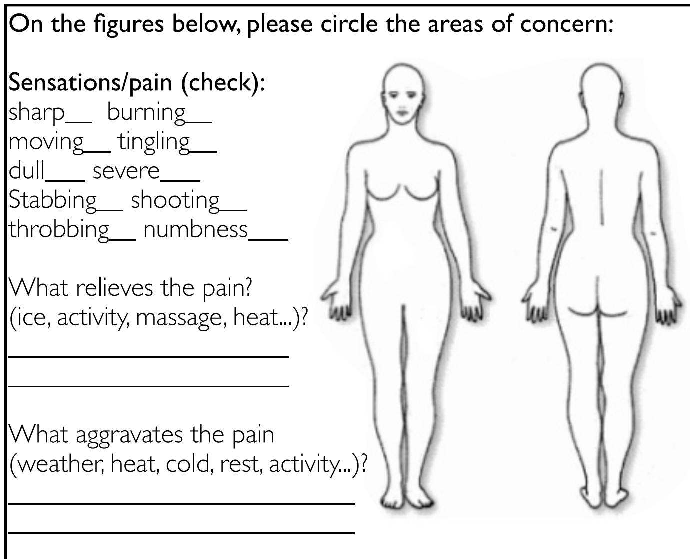
	Heart Condition		Stroke		High blood pressure		Low blood pressure
	Diabetes		Kidney disorder		Neurological		Spinal or head injury
	Respiratory		Sprain/Strain/Fracture		Cancer		Hepatitis
	HIV/ AIDS		Arthritis		Osteoporosis		Headaches/migraines
	Jaw pain		Digestive problems		Dizziness/fainting		Contagious illness
	Skin condition		Epilepsy		Haempophiliac		Wear a pacemaker
	Lung condition		Depression		Possibly pregnant?		Upcoming surgeries
	Pneumonia		Mental Illness		Allergies		Liver Disease

On the figures below, please circle the areas of concern:

Sensations/pain (check):
sharp__ burning__
moving__ tingling__
dull___ severe___
Stabbing__ shooting__
throbbing__ numbness___

What relieves the pain?
(ice, activity, massage, heat...)?
____
____

What aggravates the pain
(weather, heat, cold, rest, activity...)?
____
____



Please list any current medication taking:

1	2
3	4
5	6

Please list any current herbal or supplements taking:

1	2
3	4
5	6

Please list any allergies (food, drugs, environmental):

1	2
3	4
5	6

Have you ever been hospitalized for any serious conditions or surgeries? Please explain below:

Do you use the following? If so, how often? Cigarettes:_____ Alcohol: _____ Drugs: _____ Coffee: _____ Pop:_____

Do you participate in the following physical activities? If so, indicate how often:			
Yoga:	Running:	Fitness:	Gym:
Biking	Swimming:	Walking:	Other:

For each symptom below that you currently have, rate its severity from 1-5 (5 being worst). Leave blank if N/A.

Gan
__ Irritability/ frustration / impatient
__ Depression
__ Stress
__ Emotional Eating
__ Unfulfilled desires
__Visual problems / floaters
__ Blurred vision / poor night vision
__ Red / Dry / Itchy eyes
__ Headaches / Migraines
__ Dizziness
__ Feeling of lump in throat
__ Muscle twitching / spasm
__ Neck / shoulder tension
__ Brittle nails
__ Sighing
__ Sensation or pain under rib cage
__ PMS
__ Genital itching/ pain /rashes

Xin
__ Palpitations
__ Chest pain / tightness
__ Insominia / Sleep problems
__ Restlessness / easily agitated
__Vivid dreams
__ Lack of joy in life
__ Forgetful
__ Aversion to heat
__ Bitter taste in mouth
__Tongue / mouth ulcers / cankers

Shen
__ Frequent urination
__ Bladder infection
__ Lack of Bladder control
__ Wake to urinate
__ Feel cold easily
__ Cold hands / feet
__ Night sweats / Hot flushing
__ Low sex drive
__ High sex drive
__ Loss of head hair
__ Hearing problems
__ Crave salty foods
__ Fear
__ Poor long term memory
__ Ankle swelling
__ Tinnitus

Fei
__ Dry cough
__Cough with Phlegm
__ Nasal discharge / drip
__ Sinus infection / congestion
__ Itchy / painful throat
__ Dry mouth / throat / nose
__ Skin rashes / hives
__ Snoring
__ Grief / Sadness
__ Shortness of Breath
__ Allergies / asthma
__ Weak immune system
__ Alternate fever / chills

Pi
__ Heaviness in the head / body
__ Fatigue / after eating
__ Difficult getting up in the morning
__ Water retention
__ Muscle tired / weak
__ Bruise easily
__ Unusual bleeding-stool, nose, etc.
__ Bad breath
__ Poor appetite
__ Increased appetite
__Crave sweets
__ Poor digestion
__ Nausea / vomiting
__ Bloating / Gas
__ Hemorrhoids
__ Constipation
__ Loose Stool
__ Alternate constipation / loose
__ Abdominal pain
__ Intestinal pain / cramping
__ Heartburn
__ Pensive / over-thinking
__ Overweight
__ Foggy mind
__Yeast infection
__ Aversion to cold
__Cold nose
__ Increased thirst
__ Prefer Warm / Cold drinks
__ Sweat easily

On a scale of 1- 10, how would you rate your daily energy level (10 being best)?

What is your occupation? Do you enjoy your work? Stress?

Are your bowel movements regular? How many per day/ week? Are they formed, loose, constipated?

Do you experience urinary frequency, urgency, burning, dribbling, retention? What colour/shad of yellow is it? Do you have a history of urinary tract infections?

How glasses of water to you drink in a day?

How many times in your life have you taken Antibiotics? How many time have you taken oral steroids?

Please describe in general what you eat, and what you crave: (spicy, salty, sweet, organic, wheat ,dairy, meat, veggies, fruit, pasta, sandwiches, soup, etc.)

Do you have trouble falling asleep? Are you a light sleeper? How many hours per night? Do you have vivid dreams? If so, what are they about? Wake and have difficult falling back to sleep?

If you were to describe yourself from an emotional standpoint, what would you say (irritable, worrier, anxious, sad, impatient, stressed, etc.)?

Date Last Menses Began:	Is your menstrual cycle: Regular ____ Irregular ____

How old were you when you had your first menstruation?________	How many days do you bleed in total? _________
	Menstrual cycle length (i.e. 26-30 days) _________

Describe your flow: Heavy___ Light ___ Average___ **Consistency of blood:** Watery __ Thick __ Average __

Does your blood contain clots? Yes ___ No ___ **At which point during the cycle?** Start __ Mid __ End __

Describe the colour of your blood: (red, dark red, brown, purple, brownish red, bright red, pink, etc.)

Do you experience any spotting?: Yes___ No___ For how days? _________

Do you experience menstrual pain? Yes ___ No ___	Before menses___ During (whcich days?)___ After ___
What relieves the pain?	Stabbing___ Cramping___ Dull___ Heavy___ On/Off___

Do you experience pre-menstrual symptoms (PMS)? Yes ___ No___ Please check all that apply below

Breast tenderness __ Cramps __ Acne__ Change in Bowel __ Bloating __ Headaches __ Nausea __ Moodiness __ Fatigue __ Night sweats __ Sleep disturbances __

Please list any other pre-menstrual symptoms

Do you ovulate on your own? Yes__ No__ What day?___	Do you chart your cycle? (circle) BBT / Ovulation sticks / Saliva
Do you experience pain around ovulation? Yes__ No__	Do your breasts get tender around ovulation? Yes__ No__

Do you notice stretchy clear egg white slippery cervical mucous around ovulation? Yes___ No___

How many times have you been pregnant? ____ How many times have you given birth? _____
Ages of children ____________ Sex of children _____________ Given names___________________________
Have you had any miscarriages? Yes_____ No_____
If yes, how many, at how many weeks pregnancy, and in what year(s)__________________________________
____
How many times have you had a D&C performed? ________
How many abortions have you had? _______ In what year(s)?_______________________
Were there any problems that occurred during these pregnancies?___________________________________

Have you ever been diagnosed with:

STD?.................................Yes__ No__ Pelvic Inflammatory disease?..........Yes__ No__ Uterine fibroids?..........Yes__ No__ Polyps?..........Yes__ No__ Pelvic adhesions?..........Yes__ No__ Prolapsed uterus?..........Yes__ No__ Unique shape of uterus?..........Yes__ No__ Endometriosis?..........Yes__ No__ PCOS (polycystic ovarian syndrome)?..........Yes__ No__	Date of last pap smear: ___/___/___ (dd/mm/yyyy) Have you ever had an abnormal paper smear? Yes___ No___ Have you ever had a cervical biopsy or operation? Yes___ No___ Do you get yeast infections regularly? Yes___ No___ Do you get bladder infections regularly Yes___ No___ If answered yes, list STD's_____________________________

Do you experience vaginal discharge? Yes___ No___ If yes, what colour? White___ Yellow___ Green___ Pinkish___ Red___ If yes, what consistency? Watery/thin ___ Thick___ Sticky___ If yes, does it have a foul odour? Yes___ No___	Have you taken oral contraceptives? Yes___ No___ If yes, for how long?______________ When did you stop?______________ Have you ever had an IUD? Yes___ No___ Have you ever taken Depo-Provera? Yes___ No___

What is your partner's name?	How long have you been married or living together?
How long have you been trying to conceive?	Are they supportive of your wishes to conceive? Yes__ No__
Have either you or your partner had a western medical diagnosis relating to fertility? Yes___ No___ What was the diagnosis? Who made the diagnosis?	

Have you had any hormone lab test performed? ie day 3/21 FSH...................... __Normal __High __Low Estrogen, E2........ __Normal __High __Low Progesterone..... __Normal __High __Low Prolactin............. __Normal __High __Low Thyroid.............. __Normal __High __Low Testosterone..... __Normal __High __Low Other:________ __Normal __High __Low	Have you taken medication to help you ovulate? Yes___ No___ If yes, what kind? ______________________ For how many cycles?___________________ Have you had your uterine/fallopian tubes evaluated medically (HSG)? Yes___ No___ What were the results? _____________________ Have you had any tubal operations? Yes___ No___

Have you ever undergone assisted reproductive treatments? (IUI, IVf, ICSI, superovulation, etc.) Yes___ No___			
Month / Year	Type of Treatment	Clinic	Results
How did you respond to the fertility treatments? Poor___ Good / average ___			

What expectations do you have of your Acupuncture treatments? Please provide the wellness goals you wish to obtain here:

List your main health concerns in order of importance to you:		
1	2	3

Informed Consent for Acupuncture Treatment

You are the most important person on your health care team. You are entitled to receive clear and understandable information about the options for and methods of therapy, techniques used, and duration of therapy. If you have questions about your treatment, please ask your attending Registered Acupuncturist to further explain it all pertinent information's in regards to your treatment. You may also seek a second opinion from another health care professional, or terminate therapy at any time.

I hereby request and consent to the performance of traditional Chinese medicine treatments and other procedures within the scope of the practice of traditional Chinese medicine on me by the Anna Totzke a Registered Acupuncturist.

I understand that methods of treatment may include, but are not limited to: acupuncture, cupping therapy, moxibustion, Chinese nutritional and traditional Chinese medicine counseling, and Chinese exercise therapy.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is an also common side effect of cupping therapy. Anna Totzke R. Ac uses sterile disposable needles and maintains a clean and safe environment.

I understand and am informed that, as in the practice of traditional Chinese medicine, with acupuncture there are some risks to treatment, including but not limited to strains, bruising and local pain. **Also, I will notify the Acupuncturist who is caring for me if I am or become pregnant.**

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

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of the Acupuncture and procedures, and have had an 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 from A. Totzke.

Patient's Name ______________________________________

Patient's Signature____________________________________ **Date Signed** __________________

Fees, Insurance and Payment Agreement

The fees charged in our clinic are comparable to those charged by other specialists with similar qualifications in this geographic area.
The fees for the clinical services are payable at the time of the visit.

We accept cash and personal cheques.

If you carry extended health insurance covering for any service that we offer, we will provide you with the necessary invoices for you to receive reimbursement.

Cancellation Policy

At our clinic, we all believe in respecting time. We will always do our best to prevent you from waiting before your appointments and/or having to change your appointments. We ask that, in return, you also respect our time. Please kindly give 48 hours notice if you need to change your appointment so another client can utilize that time slot. We reserve the right to charge full price for less then 48 hours cancellations and missed appointments (“no shows”.)

Please sign below indicating that you have read the policy and agree to its terms.

Name: ____