

**ACUPUNCTURE: FEMALE FERTILITY
INITIAL INTAKE FORM**

Date:

Last Name: First Name: circle: **Mr. Ms. Mrs. Dr.**

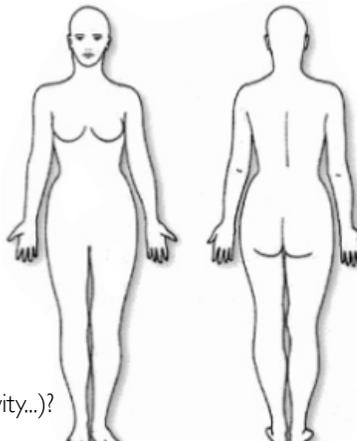
Birth date:	Age:	Phone (home):
Address:		Phone (work):
		Phone (cell):
Email:	Occupation:	
Reason for Visit:	Family Physician Name:	
	Family Physician Phone:	

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

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

<p>Gan</p> <ul style="list-style-type: none"> <input type="checkbox"/> Irritability/ frustration / impatient <input type="checkbox"/> Depression <input type="checkbox"/> Stress <input type="checkbox"/> Emotional Eating <input type="checkbox"/> Unfulfilled desires <input type="checkbox"/> Visual problems / floaters <input type="checkbox"/> Blurred vision / poor night vision <input type="checkbox"/> Red / Dry / Itchy eyes <input type="checkbox"/> Headaches / Migraines <input type="checkbox"/> Dizziness <input type="checkbox"/> Feeling of lump in throat <input type="checkbox"/> Muscle twitching / spasm <input type="checkbox"/> Neck / shoulder tension <input type="checkbox"/> Brittle nails <input type="checkbox"/> Sighing <input type="checkbox"/> Sensation or pain under rib cage <input type="checkbox"/> PMS <input type="checkbox"/> Genital itching/ pain /rashes <p>Xin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Palpitations <input type="checkbox"/> Chest pain / tightness <input type="checkbox"/> Insomnia / Sleep problems <input type="checkbox"/> Restlessness / easily agitated <input type="checkbox"/> Vivid dreams <input type="checkbox"/> Lack of joy in life <input type="checkbox"/> Forgetful <input type="checkbox"/> Aversion to heat <input type="checkbox"/> Bitter taste in mouth <input type="checkbox"/> Tongue / mouth ulcers / cankers 	<p>Shen</p> <ul style="list-style-type: none"> <input type="checkbox"/> Frequent urination <input type="checkbox"/> Bladder infection <input type="checkbox"/> Lack of Bladder control <input type="checkbox"/> Wake to urinate <input type="checkbox"/> Feel cold easily <input type="checkbox"/> Cold hands / feet <input type="checkbox"/> Night sweats / Hot flushing <input type="checkbox"/> Low sex drive <input type="checkbox"/> High sex drive <input type="checkbox"/> Loss of head hair <input type="checkbox"/> Hearing problems <input type="checkbox"/> Crave salty foods <input type="checkbox"/> Fear <input type="checkbox"/> Poor long term memory <input type="checkbox"/> Ankle swelling <input type="checkbox"/> Tinnitus <p>Fei</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dry cough <input type="checkbox"/> Cough with Phlegm <input type="checkbox"/> Nasal discharge / drip <input type="checkbox"/> Sinus infection / congestion <input type="checkbox"/> Itchy / painful throat <input type="checkbox"/> Dry mouth / throat / nose <input type="checkbox"/> Skin rashes / hives <input type="checkbox"/> Snoring <input type="checkbox"/> Grief / Sadness <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Allergies / asthma <input type="checkbox"/> Weak immune system <input type="checkbox"/> Alternate fever / chills 	<p>Pi</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heaviness in the head / body <input type="checkbox"/> Fatigue / after eating <input type="checkbox"/> Difficult getting up in the morning <input type="checkbox"/> Water retention <input type="checkbox"/> Muscle tired / weak <input type="checkbox"/> Bruise easily <input type="checkbox"/> Unusual bleeding-stool, nose, etc. <input type="checkbox"/> Bad breath <input type="checkbox"/> Poor appetite <input type="checkbox"/> Increased appetite <input type="checkbox"/> Crave sweets <input type="checkbox"/> Poor digestion <input type="checkbox"/> Nausea / vomiting <input type="checkbox"/> Bloating / Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Constipation <input type="checkbox"/> Loose Stool <input type="checkbox"/> Alternate constipation / loose <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Intestinal pain / cramping <input type="checkbox"/> Heartburn <input type="checkbox"/> Pensive / over-thinking <input type="checkbox"/> Overweight <input type="checkbox"/> Foggy mind <input type="checkbox"/> Yeast infection <input type="checkbox"/> Aversion to cold <input type="checkbox"/> Cold nose <input type="checkbox"/> Increased thirst <input type="checkbox"/> Prefer Warm / Cold drinks <input type="checkbox"/> Sweat easily
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<p>On a scale of 1- 10, how would you rate your daily energy level (10 being best)?</p> <p>What is your occupation? Do you enjoy your work? Stress?</p> <p>Are your bowel movements regular? How many per day/ week? Are they formed, loose, constipated?</p> <p>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?</p> <p>How glasses of water to you drink in a day?</p>	<p>How many times in your life have you taken Antibiotics? How many time have you taken oral steroids?</p> <p>Please describe in general what you eat, and what you crave: (spicy, salty, sweet, organic, wheat ,dairy, meat, veggies, fruit, pasta, sandwiches, soup, etc.)</p> <p>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?</p> <p>If you were to describe yourself from an emotional standpoint, what would you say (irritable, worrier, anxious, sad, impatient, stressed, etc.)?</p>
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Date Last Menses Began: _____	Is your menstrual cycle: Regular ____ Irregular ____
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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 (which 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 ____	Date of last pap smear: ____/____/____ (dd/mm/yyyy)
Pelvic Inflammatory disease?.....Yes ____ No ____	Have you ever had an abnormal paper smear? Yes ____ No ____
Uterine fibroids?.....Yes ____ No ____	Have you ever had a cervical biopsy or operation? Yes ____ No ____
Polyps?.....Yes ____ No ____	Do you get yeast infections regularly? Yes ____ No ____
Pelvic adhesions?.....Yes ____ No ____	Do you get bladder infections regularly? Yes ____ No ____
Prolapsed uterus?.....Yes ____ No ____	If answered yes, list STD's _____
Unique shape of uterus?.....Yes ____ No ____	
Endometriosis?.....Yes ____ No ____	
PCOS (polycystic ovarian syndrome)?.....Yes ____ No ____	

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___
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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___
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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:
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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.

Parents/Guardians I agree that I am solely responsible for the safety of my child/children while on the premise of TouchStone Health. Children are to be supervised at all times and never left unattended by the parent.

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 than 48 hours cancellations and missed appointments (“no shows”).

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

Name: _____