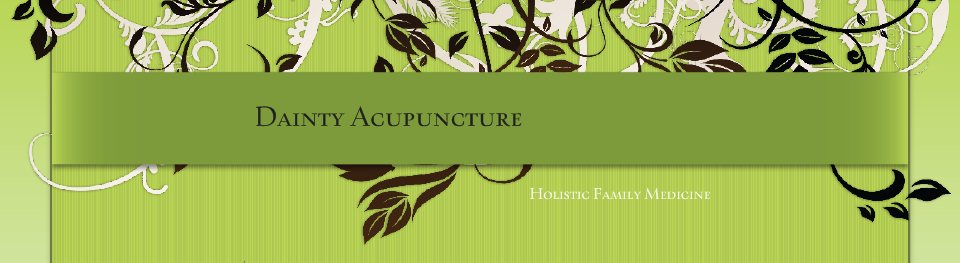


Patient Information

|  |
| --- |
| First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I.\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_  Gender M F Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­  Married □ Single □ Domestic Partner □  Name of Spouse/Partner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Referred By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | |  | |



**Female Fertility Questionnaire**

Name (Last, First, Middle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Menses**

Age at which menses began \_\_\_\_\_\_\_

Are your periods painful? Yes No

How many days do you normally bleed? \_\_\_\_\_\_\_

How heavy is the bleeding? Light Normal Heavy

What color is the blood? Light red Red Dark red Purple Brown Black

Is there clotting? Yes No

Does your face break out before or during your period? Yes No

Do your breasts become tender premenstrually? Yes No

Do you get premenstrual low back pain? Yes No

Do you bleed or spot between periods? Yes No

Are your menstrual cycles spaced irregularly? Yes No

How many days are there from one period to the next? \_\_\_\_\_\_\_

Date of last menstrual period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have your cycles changed since they began? Yes No

Do you ovulate on your own? Yes No On what day of your cycle? \_\_\_\_\_\_\_\_\_

Do your breasts get tender at/during ovulation? Yes No

Do your bowel movements become loose at the beginning of your period? Yes No

**Western Diagnosis**

Have you ever been diagnosed with uterine fibroids or polyps? Yes No

Have you ever had pelvic inflammatory disease? Yes No Were you treated for it? Yes No

Have you ever been diagnosed with endometriosis? Yes No

Have you been diagnosed with pelvic adhesions? Yes No

Have you been diagnosed with any pelvic abnormalities? Yes No

Have you had surgeries besides a D&C? Yes No When?\_\_\_\_\_\_\_\_\_\_\_\_\_ What kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication History**

Have you taken oral contraceptives? Yes No When? \_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_

Have you ever had an IUD? Yes No When? \_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_

Have you ever taken DepoProvera? Yes No When? \_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_

Have you taken medication to help you ovulate? Yes No When? \_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_

Are you presently taking steroids? Yes No

Please list all medications currently taking\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy History**

How many pregnancies have you had? \_\_\_\_\_\_

How many children do you have? \_\_\_\_\_\_

Were there complications during your pregnancies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many abortions have you had? \_\_\_\_\_\_

How many miscarriages have you had? \_\_\_\_\_\_

How many times has a D & C been performed? \_\_\_\_\_\_

**Well-Women History**

Have you ever had an abnormal pap smear? Yes No

Have you ever had a cervical biopsy, operation, cauterization or conization? Yes No

Have you ever had a venereal disease? Yes No What kind? \_\_\_\_\_\_\_\_\_\_\_

Do you get yeast infections regularly? Yes No

Do you have chronic vaginal discharge? Yes No

**Fertility Treatments**

Have you had fertility treatments? Yes No

If yes, when and where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What types? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a diagnosis relating to infertility? Yes No What was it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have your fallopian tubes been evaluated medically? Yes No What were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any tubal operations? Yes No

Have you had any hormone laboratory tests performed? Yes No What were the results?

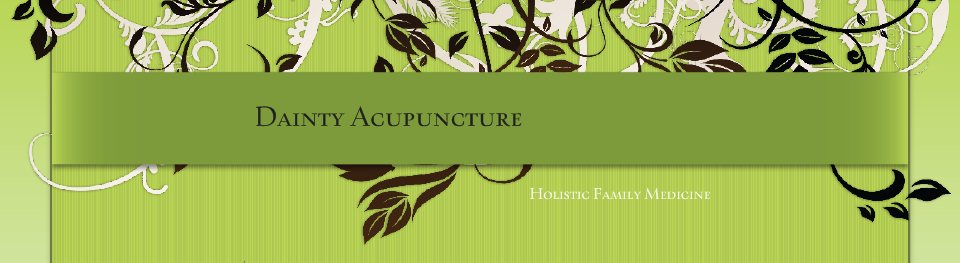
Do you have a single partner with whom you have been trying to conceive? Yes No

Has he had a fertility workup? Yes No What were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your partner supportive of your wish to conceive? Yes No

How long have you been trying to conceive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your sexual energy? Low Normal High



**Patient Consent for Use and Disclosure of Protected Health Information**

With my consent, Dainty Acupuncture (DA), may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

We will not release this information unless we receive a subpoena or an Authorization to Release Records signed by you.

DA may call my home or other designated location and leave a message on voice mail or in person, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance information, and any call pertaining to my clinical care.

DA may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patients statements marked Personal and Confidential.

DA may email me appointment reminders and patient statements.

I have the right to request that DA restrict how it uses or discloses my PHI to carry out TPO. By signing this form, I am consenting to DA use and disclosure of my PHI to carry out TPO.

I may revoke my consent at any time in writing. If I do not sign this consent, DA may decline to provide treatment to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

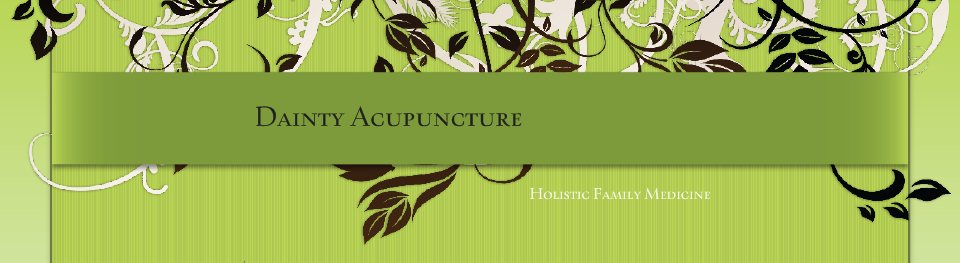
Signature of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date



**Terms and Conditions of Service**

Acupuncture Information and Guidelines

Acupuncture is designed to naturally balance, heal, and rejuvenate the body. In order to fully absorb and integrate the benefits of your treatment, avoid strenuous activity or stressful situations for the remainder of the day. Please drink plenty of water after your treatment. Please inform your practitioner of any sensitivities, injuries, or transmittable diseases to ensure your safety, and the safety of your practitioner.

Office Policies

Cancellations and rescheduling of appointments must be done at least 24 hours in advance. You will be charged the full price of your service for any cancellations made less than 24 hours before the scheduled appointment. A bill will be mailed to the address you provided to us. A $25.00 fee will be charged for any returned checks. Returned checks must be replaced by a secured form of payment (credit card or cash). Payment is due when services are rendered. By signing below, you authorize the release of any information necessary to your insurance company in order to process your claim. Should accounts be referred to an attorney or collection agency, attorney’s fees and collection expenses incurred shall be payable in addition to the other previous amounts due.

Medical Records

Dainty Acupuncture will not release your records to anyone unless you have signed the “Release of Records” form, or we are instructed to do so by a subpoena or your insurance company. You give Dainty Acupuncture permission to obtain medical records from previous physicians or medical centers.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date