INDIGO
HEALING ACUPUNCTURE

Women's Fertility Health History

Important: The information on this form will help your acupuncturist give you the best and most comprehensive care possible. It is important for you to complete this document as thoroughly as possible. Even though some of the questions may seem completely unrelated to your condition, they may play a contributing, or underlying role in diagnosis and treatment of your problem.

General Patient Information (*All of the information provided is strictly confidential – see permission to share medical information section*)

Last Name:_____ First Name:_____ Middle Initial:_____ Age: _____

Primary Telephone Number:_____ Alternative Phone # _____

E-Mail:_____ Date of Birth_____/_____/_____ Text Message Ok? (circle one) Yes / No

Number of:

Pregnancies	
Cesarean Births	
Vaginal Births	
Abortions	
Miscarriages	
Ectopic(s)	
Failed IUI's	
Failed IVF's	

Medical Providers:

Ob/Gyn: _____

Reproductive Endocrinologist: _____

Midwife: _____

Chiropractor: _____

Previous Gynecological Surgeries - *Check any surgical procedure that you have had*

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

Previous Diagnostic Assessments - *Check any diagnosis received by your OB/GYN or Fertility Doctor*

☐ Advanced Maternal Age
☐ Amenorrhea
☐ Anovulation
☐ Anti-sperm Antibodies
☐ Autoimmune Oopharitis
☐ Cervical Stenosis
☐ Elevated FSH_____
☐ Endometriosis (mild, moderate, severe)
☐ Erratic Cycles_ -_____Days
☐ 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):
☐
☐
☐

List any Fertility Drugs you have taken:_____

Medications you currently take: _____

Please list any non-prescription or recreational drugs you currently take (eg. vitamins and supplements):

_____

Menstrual Cycle

Age menstruation began: _____

How long have you been trying to get pregnant? _____

My periods are: (please circle one)

a) Like clockwork
b) Somewhat regular
c) Erratic

Number of days in a typical menstrual cycle: ___

If your cycle is erratic:

Shortest # of days in cycle: _____

Longest # of days in cycle: _____

Menstrual bleeding tends to be:

a) Light b) Normal c) Heavy

On what cycle day do you typically ovulate? _____

During ovulation, is your cervical mucus clear, stretchy and abundant?

☐ Yes ☐ No

If not all three of these, describe:

_____

Is there clotting with your period?

☐ Yes ☐ No Color of clots? _____

Do you have spotting before between periods? ☐ Yes ☐ No

Do you regularly experience PMS?

☐ Yes ☐ No

(Circle which PMS symptoms you get)

Breast tenderness - Diarrhea - Acne
Bloating - Constipation - Back Pain
Food Cravings - Dizziness - Fatigue
Headache or Migraine - Mood Swings
Pain with Period

Personal and Contact Information

Address:_____ City:_____ State:_____ Zip:_____

Occupation:_____ Employer:_____

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

Significant Other's Name:_____ SO's Age:_____

Significant Other's Occupation: _____

Has your male partner had a semen analysis? Y / N Results:_____

In case of emergency, whom should we notify?_____

Relationship:_____ Contact Number:_____

General Health Information

Do You Exercise Regularly? Y / N If so, what forms of exercise? _____

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

Major Health Complaints / Symptoms	Additional Health Complaints / Symptoms
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

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 that you have had in the past, or are currently experiencing):

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Rheumatic fever
☐ Heart Disease	☐ Stroke	☐ Vein condition	☐ Thyroid disorder
☐ Asthma	☐ Pneumonia	☐ Tuberculosis	☐ Emphysema
☐ Hepatitis	☐ Gonorrhea	☐ Mumps	☐ Bleeding or hemorrhage
☐ Syphilis	☐ Measles	☐ ChickenPox/Shingles	☐ Nervous disorder
☐ Meningitis	☐ HIV	☐ Polio	☐ Auto Immune Disease
☐ Epilepsy	☐ High Fever	☐ Hepatitis	☐ Hypertension
☐ Paralysis	☐ Cancer	☐ Migraines	☐ Mental Illness
☐ Lung disease	☐ Heart disease	☐ Liver disease	☐ Kidney disease
☐ Headache	☐ Chlamydia	☐ High Cholesterol	☐ Irregular Pap Smear
☐ Other _____			

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 organ's function; this information will assist with your Chinese Medicine diagnosis.)

Body Temperature (Kidney Organ System)

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

Energy and Stamina (Lung and Kidney System)

☐ Easily fatigued	☐Lethargy	☐Easily prone to illness	☐Wheezing
☐ Shortness of breath	☐Sweating without exertion	☐Frequent colds / flus / sinuses	☐Chronic allergies

Blood Function (Liver, Heart and Spleen System)

☐ Dizziness	☐Tingling in extremities	☐Itchy or dry	☐ Blurry vision
☐ Poor night vision	☐Poor memory	☐Scanty menses	☐ Tinnitus
☐ Floaters	☐Difficulty concentrating	☐Fainting	☐ Weak or brittle nails

Heart Function

☐ Heart palpitations	☐Manic moods	☐ Forgetfulness	☐ Tongue ulcers
☐ Anxiety	☐Restless dreams	☐ Hallucinations	☐ Speech impediment
☐ Mental restlessness	☐Insomnia	☐ Depression	☐ Severe shyness
☐ Chest Pain	☐Arrhythmia	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Hemophilia	☐Rapid Heart Beating	☐ Heart Murmur	☐ Mitral valve prolapse

Lung Function

☐ Persistent cough	☐Chronic allergies	☐ Dry or flaky skin	☐ Headaches
☐ Nosebleeds	☐Nasal dryness	☐ Sneezing	☐ Difficulty breathing
☐ Sinus congestion	☐Sore throats	☐ Wheezing	☐ Cigarette smoking

Allergies to ☐ Mold ☐ Cedar ☐ Pet fur ☐ Dust ☐ Pollen ☐ Oak ☐ Hay Fever ☐ 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 [Level of determination to quit - 1 2 3 4 5 6 7 8 9 10]

Spleen Function

☐ Low or weak	☐ 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
☐ Diarrhea
☐ Incomplete stools
☐ Constipation
☐ Blood in stools
☐ Mucous in stools
☐ Difficulty moving bowels
☐ Small, hard, dry stools
☐ Less than 1 BM/ Day
☐ I.B.S. or Colitis
☐ Crohn's Disease
☐ Eating Disorder

Accumulated Dampness

☐ Mental fogginess
☐ Mental sluggishness
☐ Poor mental focus
☐Heaviness of the head, the limbs, or of the whole body
☐ Swollen hands
☐ Swollen feet
☐ Joint stiffness/ ache
☐ Symptoms worsen in rainy weather
☐ Edema in the legs
☐ Edema in the abdomen
☐ Chest congestion

Liver and Gall Bladder Function

☐ Chest pain
☐ Chest tightness
☐ All over body tension
☐ Muscle spasms
☐ Muscle cramps
☐ Seizures
☐ Alternating diarrhea and constipation
☐ Irritability
☐ Easy to anger
☐ Easily frustrated
☐ Convulsions
☐ Numbness / tingling
☐ Lump in throat
☐ Easily overwhelmed by stress
☐ Depression
☐ Pain in the ribcage
☐ Heaviness in ribcage
☐ Chronic neck tension
☐ Shoulder tension
☐ Ringing in ears
☐Skin rashes
☐ Acne
☐ Headaches
☐ Migraines
☐ Gall stones
☐ Eye pain / dryness

Eyes (Liver Function)

☐ Itchy eyes
☐ Dry eyes
☐ Watery eyes
☐ Grittiness
☐ Poor night vision
☐ Red and irritated
☐ Bloodshot
☐ Seeing spots
☐ Near sighted
☐Far sighted
☐Astigmatism
☐Glaucoma

Kidney and Urinary Bladder Function

☐ Frequent cavities
☐ Broken / loose teeth
☐ Weak bones
☐ Ringing in the ears
☐ Weak knees
☐ Knee soreness
☐ Low back pain
☐ Prostate problems
☐ Cold lower back
☐ Cold hips / buttocks
☐ Cold knees
☐ Incontinence
☐Hair loss
☐Early graying of hair
☐Hearing loss
☐Quick to fear / fright

Urinary Function

☐ Normal color
☐ Dark Yellow
☐ Clear color
☐ Difficulty initiating the stream of urination
☐Reddish color
☐Cloudy
☐Strong odor
☐ Dribbling
☐ Small amount
☐ Large amount
☐ Very frequent
☐ Weak stream
☐Night-time urination
☐UTI / Pain or burning
☐Hesitancy

Libido Function

☐ Normal
☐ Pain with intercourse
☐ High sex drive
☐ Fatigue following sexual activity
☐ Diminished sex drive
☐ Infertility
☐ Vaginal dryness

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 life stressful, or fast paced? Y / N

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

In what areas of your life do you feel the most stressed? Circle all that apply: Fertility process - Job/Career Partner/Spouse relationship - Parents/Family - Financial - Friends - Other(s): _____

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 being the lowest feeling of hope, and 10 being the most hopeful) 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 (I primarily rely on myself alone to deal with difficult issues)

Are you using any of the following methods of relaxation and/or healing? Massage therapy - Physical exercise Meditation - Prayer - Yoga - Guided imagery - Energy Work - Others: _____

Medical Evaluation

I was evaluated by a physician, OB/GYN, reproductive endocrinologist, or chiropractor for the condition(s) being treated within the last 12 months.
☐Yes ☐ No

I recognize that I should be evaluated by a physician for the condition(s) being treated by the acupuncturist.
☐Yes ☐ No

Permission to maintain medical privacy and share medical information

All of the information that you provide to us is strictly confidential. It is our policy never to disclose any personal or medical information about any patients under our care without first obtaining your express permission to do so. There are, however, a few instances where we feel that sharing information about your case helps to provide the best possible clinical outcome, and we would like to ask your permission to share information. -

1) Many of our patients are under the care of an OB/GYN, a Reproductive Endocrinologist, Physician, 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, Physician and/or Fertility Specialist?
☐ Yes ☐ No

_____ Patient Signature

_____ Date

Informed Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other procedures within 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, moxibustion, cupping, cold laser, electrical stimulation, Tui-Na (Chinese massage), 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 effects 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 spontaneous miscarriage, 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. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant. (Women initial here: ____)

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 results are not guaranteed.

I understand that the clinical and administrative staff may review my patient 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, the above consent to treatment, 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.

Any appointment missed, late cancelled, or changed without 24 hours notice will result in a charge equal to 100% of the reserved service amount. The appointment may be taken off of a contract/plan or charged individually.

_____	_____	_____
Patient Name (please print)	Patient Signature	Date

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number:

1-800-201-9353

For more information please visit our website at

www.tmb.state.tx.us

AVISO SOBRE LAS QUEJAS

Las quejas sobre médicos, así como sobre otros profesionales acreditados e inscritos en la Junta de Examinadores Médicos del Estado de Texas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugía, se pueden presentar en la siguiente dirección para ser investigadas:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Si necesita ayuda para presentar una queja, llame al:

1-800-201-9353

Para obtener más información, visite nuestro sitio web en

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