

## Health History Questionnaire – Women – Fertility Specific

This is a *confidential* questionnaire to help us determine the best treatment plan for you. If you have any questions, please ask. If you need more room, please use the back side of these sheets.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home (\_\_\_\_\_) \_\_\_\_\_  Work (\_\_\_\_\_) \_\_\_\_\_  Cell (\_\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

(Appointment reminders are sent via email)

May we add you to our email newsletter?  Yes  No (We will never spam or share your information)

DOB \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Height: \_\_\_ Weight: \_\_\_ Weight 1 yr ago: \_\_\_ Sex: M F MTF FTM

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Single  Married  Divorced  Separated  Widowed  Partnership  Same sex relationship

Emergency Contact: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Have you received acupuncture therapy before?  Yes  No If Yes, where? \_\_\_\_\_

### HEALTH HISTORY

1. What are the main health concerns for which you are seeking treatment?

\_\_\_\_\_ Date of Onset: \_\_\_\_\_  
 \_\_\_\_\_ Date of Onset: \_\_\_\_\_  
 \_\_\_\_\_ Date of Onset: \_\_\_\_\_  
 \_\_\_\_\_ Date of Onset: \_\_\_\_\_

2. What previous medical workups, diagnosis, and treatment have you had for these concerns?

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

3. Please list any allergies to:  Latex  Food \_\_\_\_\_  Metals \_\_\_\_\_  Drugs \_\_\_\_\_  
 Other: \_\_\_\_\_

4. Do you have any of the following:

Hepatitis  HIV  Seizures  Pacemaker  Metal pins or plates

5. List any accidents, surgeries, or hospitalizations (include date):

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

6. What medications, sleep aids, stomach remedies, vitamins, and supplements are you currently taking? (Continue on the back of this page if necessary. If you have a separate list, we can photocopy that for you.)

Medication	Dose	Reason	Date Started	Date of last checkup

7. Family history

	Mother	Father	Brother(s)	Sister(s)	Spouse	Child(ren)
Health: G=Good P=Poor						
Medical Conditions						
Age, if living						
If deceased, age and cause						

**LIFESTYLE HABITS**

8. Please indicate the use and frequency of the following: (how much, how many, or how often)

- Alcohol \_\_\_\_\_
  - Tobacco \_\_\_\_\_
  - Second Hand Smoke Exposure  Y  N
  - Marijuana \_\_\_\_\_
  - Other Recreational Drugs \_\_\_\_\_
  - Coffee \_\_\_\_\_
  - Tea \_\_\_\_\_
  - Soda Pop \_\_\_\_\_
  - Water \_\_\_\_\_
  - Energy Drinks \_\_\_\_\_
- Have you ever been treated for drug/alcohol dependence?  Yes  No

9. Do you follow any particular diet or eating style:

\_\_\_\_\_

How many times a week do you eat at restaurants?  0-2  3-5  6 or more

How many meals per day do you eat? \_\_\_\_\_ How many snacks per day? \_\_\_\_\_

10. What is your daily activity level including your occupation:

- Sedentary, i.e. mostly sitting
- Somewhat active
- Moderately active
- Very active (moving around or up most of the time)
- Heavy duty (lifting, moving things, etc.)

11. Do you sleep well?  Yes  No Awaken rested?  Yes  No Average hours of sleep: \_\_\_\_\_

12. What is your average energy level (1 – least, 10 – most): 1 2 3 4 5 6 7 8 9 10

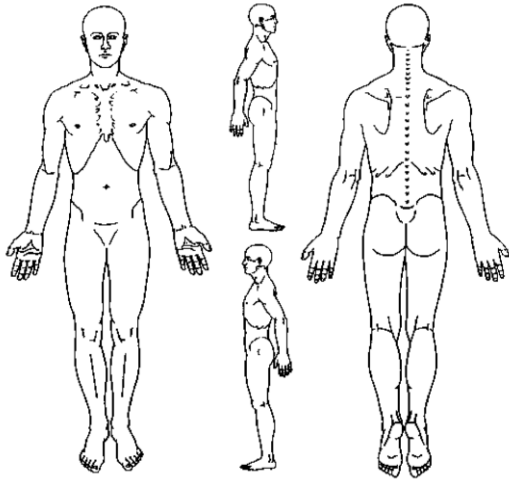
13. What is your average stress level (1 – least, 10 – most): 1 2 3 4 5 6 7 8 9 10

14. How much change are you willing to/able to make at this time to improve your health?

- Minimal
- Some
- Complete



**PAIN**



Please mark on the picture where you have pain right now:

A=Ache                      B=Burning      N=Numbness  
P=Pins & Needles      S=Stabbing      O=Other

How long: \_\_\_\_ Years \_\_\_\_ Months \_\_\_\_ Weeks

How painful is it? (0=none to 10= excruciating) \_\_\_\_\_

Better with:  Movement  Rest  Pressure  Heat  Ice  
 Medicine \_\_\_\_\_  Other \_\_\_\_\_

Worse with:  Movement  Rest  Pressure  Heat  Ice  
 Medicine \_\_\_\_\_  Other \_\_\_\_\_

**SYMPTOM SURVEY**

Check symptoms experienced *in the past 3 months*. Leave blank if never experience.

Please indicate as follows:    One check = ✓ = Sometimes            Two checks = ✓ ✓ = Frequently

- \_\_\_ Appetite  High  Low
- \_\_\_ Thirst  High  Low
- \_\_\_ Constipation
- \_\_\_ Loose stool/diarrhea
- \_\_\_ Colitis or diverticulitis
- \_\_\_ Hemorrhoids
- \_\_\_ Indigestion/Acid reflux
- \_\_\_ Ulcers
- \_\_\_ Belching/burping/gas
- \_\_\_ Abdominal bloating
- \_\_\_ Unexplained weight loss
- \_\_\_ Difficult to digest oily food
- \_\_\_ Gallstones
- \_\_\_ Mucus in stool
- \_\_\_ Bloody or black tarry stool
- \_\_\_ Undigested stool

- \_\_\_ Palpitations/fluttering
- \_\_\_ Chest pain
- \_\_\_ Bronchitis
- \_\_\_ Cough
- \_\_\_ Coughing blood
- \_\_\_ Shortness of breath
- \_\_\_ COPD/Emphysema
- \_\_\_ Allergies
- \_\_\_ Catch colds easily
- \_\_\_ Asthma
- \_\_\_ Sinus congestion
- \_\_\_ Recent use of antibiotics
- \_\_\_ Phlegm:  Nose  Chest
- Easy to expectorate:  Y  N
- Color: Clear White Yellow Green

- \_\_\_ Tension headache
- \_\_\_ Migraine
- \_\_\_ Worry/Mind Racing
- \_\_\_ Difficulty concentrating
- \_\_\_ Poor memory
- \_\_\_ Fatigue
- \_\_\_ Laughing for no reason
- \_\_\_ Easily angered/agitated
- \_\_\_ Difficulty w/ decisions
- \_\_\_ Dizziness/lightheaded
- \_\_\_ Easily startled
- \_\_\_ Eye problems
- \_\_\_ Ear ringing
- \_\_\_ Impaired hearing

- \_\_\_ Acne
- \_\_\_ Eczema
- \_\_\_ Psoriasis
- \_\_\_ Rashes
- \_\_\_ Itching
- \_\_\_ Dandruff

- \_\_\_ Muscle spasms/twitching
- \_\_\_ Soft brittle nails
- \_\_\_ Easily bruised
- \_\_\_ Yellowish skin/eyes
- \_\_\_ Hair loss/early gray
- \_\_\_ Temperature:  Run cold  Run warm  Neutral
- \_\_\_ Sweating:  Easily  Rarely  Hot flashes  Night sweats
- \_\_\_ Decreased libido
- \_\_\_ Urinary problems
- \_\_\_ Urine color \_\_\_\_\_
- \_\_\_ Edema/swelling
- \_\_\_ Kidney stones

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad	Comments
Significant Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self image	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have any history of physical, sexual, or emotional abuse?  Yes  No

**FEMALE PATIENTS**

Age of first period \_\_\_\_\_ Date and result of most recent Pap exam \_\_\_\_\_

**Menstruation:**

First day of most recent period \_\_\_\_\_ Length between periods \_\_\_\_\_ Birth control \_\_\_\_\_

Regularity:  Regular  Irregular  Usually early  Usually late # Days of Flow: \_\_\_\_\_

Flow is typically:  Heavy  Moderate  Light

Color is typically:  Pale pink  Red  Bright red  Dark red  Purplish  Brownish

Consistency is typically:  Thin  Thick  Clotted

Discomfort with period:  Abdominal bloating  Lower back soreness  Cramping/pain

Premenstrual Syndrome (PMS):  Other \_\_\_\_\_

Irritability  Bloating  Mood swings  Breast tenderness  Water retention

Other symptoms related to menses:

Vaginal dryness  Headache  Nausea  Diarrhea  Constipation  Insomnia  
 Ravenous appetite  Low appetite  Night sweats  Hot flashes  High libido  Low libido

**General:**

Vaginal Discharge  Uterine bleeding (not related to periods)  
 Fibroids  Fibrocystic Breasts  Endometriosis  Ovarian Cysts  PID  PCOS  
 Gonorrhea  Syphilis  Chlamydia  Herpes  HIV  HPV

**Pregnancy:**

Are you currently pregnant?  Yes  No  Not sure

Number of: Pregnancies \_\_\_\_\_ Live births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Terminations \_\_\_\_\_

Please list note any difficulties during the pregnancy and/or after delivery (for example morning sickness, edema, prolonged bleeding after delivery, gestational diabetes, high blood pressure, fever postpartum etc.)

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

**OVULATION**

1. On what cycle day do you typically ovulate? \_\_\_\_\_
2. Do you use an ovulation predictor kit to determine ovulation?  Yes  No
3. Do you chart your Basal Body Temperature?  Yes  No  
(If so, please bring a copy of your most recent 3 charts)
4. Do you experience any symptoms at ovulation?  
 Breast tenderness    Sharp pain    Cramping    Bowel movement changes    Irritability
5. Do you get cervical mucus at ovulation?  Yes  No   For how many days? \_\_\_\_\_
6. Describe the quality/quantity of your cervical mucus:  
 None    Scant    Moderate    Profuse  
 Creamy, thick    Like rubber cement    Egg-white stretchy    Watery    Other

**FERTILITY**

1. How long have you been trying to get pregnant? \_\_\_\_\_
2. Has a physician diagnosed a difficulty with fertility due to:  
 Female factor    Male factor    Unexplained  
 Other \_\_\_\_\_
3. Has your husband/partner/donor received a sperm analysis?  Yes  No  
If yes, what were the results? \_\_\_\_\_
4. Who is your OB/Gyne or Reproductive Endocrinologist? \_\_\_\_\_
5. What tests have been performed? (Circle any that were abnormal and list the result.)  
 Hormone levels:  ESTRADIOL    FSH    LH    ESTROGEN    PROGESTERONE  


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 Other blood tests: \_\_\_\_\_  
 Laparoscopy: \_\_\_\_\_  
 HSG (to check fallopian tubes): \_\_\_\_\_  
 Ultrasound: \_\_\_\_\_
6. Any uterine abnormalities? \_\_\_\_\_
7. Number of previous IVF procedures? \_\_\_\_\_ Number of IUIs? \_\_\_\_\_  
Quality/Number of eggs? \_\_\_\_\_
8. Are you currently in an IVF or IUI cycle and if so, where are you in the process and/or what is your current schedule of procedures?  


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9. What are your acupuncture treatment goals relating to your fertility?  


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**CONSENT TO TREATMENT**

I voluntarily consent to receive (or have the patient named below, for whom I am legally responsible, receive) acupuncture and traditional Chinese medicine administered by licensed acupuncturists working at Three Wells Acupuncture Clinic, Inc. who are licensed by the State of Illinois and certified by the National Certification Commission of Acupuncture and Oriental Medicine. **I understand that his/her training is in acupuncture and traditional Chinese medicine and that (s)he is not, nor claims to be, a medical doctor. I understand that the evaluation given to me in no way purports to be, or replaces, allopathic (western) medical evaluation, diagnosis, or treatment.**

I have provided a full history and description of complaints which are complete and accurate. I understand that no guarantee has been made concerning the use and effects of acupuncture and traditional Chinese medicine. I understand that I may discontinue treatment at any time.

**I understand that acupuncture is the insertion of fine, sterile, single-use needles.** As part of traditional Chinese medicine, the methods of treatment may include, but are not limited to, liniments (herbal ointments), gua sha (muscle scraping technique), cupping (myofascial release), moxa (heat therapy), tui na massage, electro-stimulation, herbal supplements, and eastern nutritional counseling, as appropriate to treatment.

**I have been informed that acupuncture is a generally safe method of treatment but that, although rare, certain side effects may result. These may include slight bleeding, minor bruising, or some discomfort at the site of needle insertion.** Other possible risks from acupuncture include dizziness, fainting, or light-headedness. Extremely rare risk of acupuncture includes nerve damage, organ puncture, and infection. Extremely rare risk of heat therapy includes discomfort or burning. The herbs and nutritional supplements (from plant, animal, and mineral sources) that have been recommended are considered safe in the practice of Traditional Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate in pregnancy. Rare but possible side effects of taking these supplements could be nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. **I will immediately notify my acupuncturist if I feel any of the aforementioned symptoms during or after an acupuncture treatment, or any unpleasant or unanticipated effects associated with the consumption of herbal supplements obtained from this clinic.** I do not expect the acupuncturist or clinical staff to be able to anticipate and explain all possible risks and complications of treatment. I will notify the acupuncturist or clinical staff if I am or become pregnant, if I have a severe bleeding disorder, or if I am wearing a pacemaker or other electronic medical device.

By signing below, I show that I have read, or have had read to me, the above consent to treatment 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.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

**CONSENT TO TREAT A MINOR CHILD** (for children and teens under 18)

I authorize the licensed practitioners at Three Wells Acupuncture Clinic, Inc. to administer acupuncture and traditional Chinese medicine as deemed necessary to my \_\_\_\_\_(relationship).

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_



## NOTICE OF PRIVACY POLICIES

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices (see separate PDF on the Forms page of the website or provided by the receptionist) and have therefore been notified of how health information about me may be used and disclosed by Three Wells Acupuncture Clinic, Inc., and how I may obtain access to and control of this information. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the operations of Three Wells Acupuncture Clinic, Inc. and its practitioner(s).

X \_\_\_\_\_  
Patient Signature or Personal Representative Date

## PAYMENT AND CANCELLATION POLICY

Payment due is to be paid at time of service. Your appointment time is specifically reserved for you. Appointment reminders via email are provided as a courtesy whenever possible, but may not always be given. ***In the event of a missed appointment or less than 24 hours' notice of cancellation, a \$25 cancellation fee will be charged.***

By signing below, I understand and accept these policies.

X \_\_\_\_\_  
Patient Signature or Personal Representative Date

## EASTERN NUTRITION INFORMED CONSENT

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "drug" is defined to mean: *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."* A vitamin is not a drug, neither is a mineral, trace element, amino acid, herb, or homeopathic remedy. Although a vitamin, mineral, trace element, amino acid, herb, or homeopathic remedy may have an effect on a disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested eastern nutritional advice is not intended as any primary treatment, nor therapy for any disease or symptom.

Herbal supplements, vitamin recommendations, or eastern nutritional advice is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

Likewise, if requested by the patient, a hair analysis from ARL laboratories is not intended as a diagnosis and does not replace the recommendations given to you by your medical doctor.

I have read and understand the above:

X \_\_\_\_\_  
Patient Signature or Personal Representative Date



**ASSIGNMENT OF BENEFITS**

(To be signed by patients who have insurance coverage for acupuncture)

I request that payment of authorized insurance benefits be made on my behalf to Three Wells Acupuncture Clinic, Inc. for any approved medical services provided to me by Three Wells Acupuncture Clinic, Inc.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original will be kept on file by Three Wells Acupuncture Clinic, Inc.

**I understand that I am financially responsible to Three Wells Acupuncture Clinic, Inc. for any charges not covered by health care benefits. It is my responsibility to notify Three Wells Acupuncture Clinic, Inc. of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.** I am responsible for the entire bill or balance of the bill as determined by Three Wells Acupuncture Clinic, Inc. and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services and products received.

X \_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date