Three Wells
ACUPUNCTURE CLINIC
nature first

105 E Main St, Suite 304, Morris IL 60450
815-942-2580 www.threewellsclinic.com

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.

Legal Name: _____Date: _____
Preferred First Name or Nickname _____

Home address: _____

City _____ State: _____ Zip: _____

❑Home (_____)_____❑Work (_____)_____❑Cell (_____)_____

Email Address: _____

DOB ___/___/____ Age: ____ Height: ____ Weight: ____ Weight 1 yr ago: ___ Gender: _____

Sex assigned at birth: _____ Pronouns: _____ Sexuality: _____ Relationship status: _____

Occupation: _____Employer: _____

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: _____

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, where? _____

5. List any accidents, surgeries, or hospitalizations (include date):(Continue on the back of this page if necessary. If you have a separate list, we can photocopy that for you.)

_____
_____

6. How much change are you willing to/able to make at this time to improve your health?
❑Minimal ❑Some ❑Complete

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7. 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**

_____
_____
_____
_____
_____
_____

8. 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

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

❑Alcohol _____ ❑ Coffee_____
❑Tobacco _____ ❑ Tea _____
❑ Second Hand Smoke Exposure ❑ Y ❑ N ❑ Soda Pop _____
❑Marijuana _____ ❑ Water _____
❑ Other Recreational Drugs _____ ❑ Energy Drinks_____

Have you ever been treated for drug/alcohol dependence? ❑ Yes ❑ No

10. Do you follow any particular diet or eating style?

_____

11. Have you ever been treated for or suspect you have disordered eating behaviors? (E.g. frequent dieting, rigid food rules, restrictions, loss of control with certain foods, excess use of laxatives, or anxiety, guilt or shame over food or exercise) ❑ Yes ❑ No
Please describe: _____

12. What is your daily activity level, including your occupation?

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

13. Do you wish to discuss food and/or activity from a weight-neutral perspective? ❑ Yes ❑ No

14. Do you sleep well? ❑ Yes ❑ No Awaken rested? ❑ Yes ❑ No Average hours of sleep: ____

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

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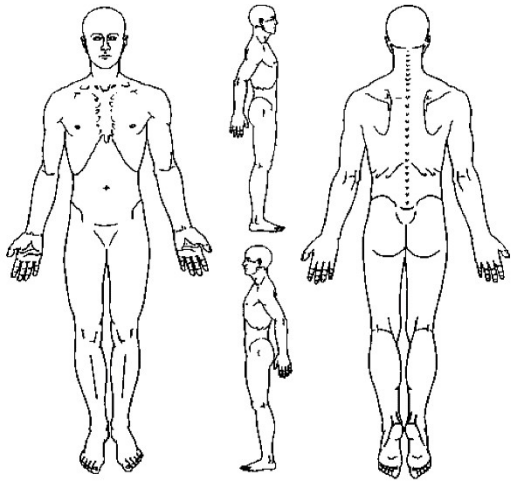
PAIN



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
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

What is the BEST part of your health right now? _____

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

	Great	Good	Fair	Poor	Bad	Comments
Significant Other	❑	❑	❑	❑	❑	_____
Family	❑	❑	❑	❑	❑	_____
Friendships	❑	❑	❑	❑	❑	_____
Diet	❑	❑	❑	❑	❑	_____
Exercise	❑	❑	❑	❑	❑	_____
Sex	❑	❑	❑	❑	❑	_____
Self-image	❑	❑	❑	❑	❑	_____
Work	❑	❑	❑	❑	❑	_____
Spirituality	❑	❑	❑	❑	❑	_____

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

FEMALE PATIENTS

1. Age of first period _____ Date and result of most recent Pap exam _____

2. **Menstruation:** (If in menopause, skip to #3 below)
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

3.**Menopause:**Age of final period _____ Any menopause symptoms? _____

4.**All women:**
❑Vaginal Discharge ❑Uterine bleeding (not related to periods)
❑Fibroids ❑Fibrocystic Breasts ❑Endometriosis ❑Ovarian Cysts ❑PID ❑ PCOS
❑ Gonorrhea ❑Syphilis ❑ Chlamydia ❑ Herpes ❑ HIV ❑ HPV

5.**Pregnancy& Adoption:**
Are you currently pregnant? ❑Yes ❑ No ❑ Not sure Adopted Children _____
Number of: Pregnancies _____ Live births _____ Miscarriages _____ Terminations _____

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

_____

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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
   _____
   ❑Other blood tests: _____
   ❑Laparascopy: _____
   ❑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?
   _____
   _____
   _____

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 and dietary supplements, essential oils, 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, nutritional supplements, and essential oils (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 supplements 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 seek medical attention, if needed.**I will also 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 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 have read the above consent and authorize the licensed practitioners at Three Wells Acupuncture Clinic, Inc. to administer acupuncture and traditional Chinese medicine as deemed necessary for my _____(relationship).

Patient's Name _____ Date_____

Parent/Guardian Signature_____ Date_____

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Clinic Policies

Welcome! We want you to be comfortable and receive the best care possible. We are here to answer any questions you might have regarding your visit, your billing, or our policies.

PAYMENT: Payment is due **at time of service**. **Amount may vary** based on whether or not you have insurance coverage, your insurance carrier, and your deductible period. **If a check is returned** for any reason, you agree to pay a **$25 service fee** and provide an alternate method for the original payment.

INSURANCE COVERAGE: Insurance coverage is **for acupuncture treatments only**. Not all plans cover acupuncture. If we submit a claim on your behalf, you understand an insurance payment is not guaranteed until a claim is processed, and you may be responsible for an additional amount, possibly up to the full balance. If you have overpaid, we will issue a refund to you.

NON-COVERED SERVICES: All non-acupuncture services and products – including hair analysis, consultations, coaching, supplements, and essential oils – are not covered by insurance and full payment is **due at time of service** or purchase.

RELEASE OF INFORMATION: If billing insurance, your carrier may require medical reports to document your treatment and progress. Your signature below **authorizes the release of medical or other information** necessary to process your claim.

ASSIGNMENT OF BENEFITS: If we are billing insurance, you **authorize payment of your medical benefits to this clinic.** If your carrier sends payments owed to us directly to you, you agree to send or bring in payment to us upon receipt.

CANCELLATION: In the event of a missed appointment or less than 24 hours' notice of cancellation, you agree to pay a $**25 cancellation fee**. More than 3 cancellations without proper notice may result in being discharged from the clinic.

NOTICE OF PRIVACY POLICY: You acknowledge you have read the Notice of Privacy Practices on the website at https://threewellsclinic.com/forms/ or asked for a paper copy from the clinic. **You have been notified of how health information about you may be used and disclosed** by Three Wells Acupuncture Clinic, Inc. and been made aware of your privacy rights.

SUPPLEMENTS AND NUTRITION: Herbal and dietary supplements, essential oil recommendations, and/or nutritional advice are **not intended as any primary treatment, diagnosis,** nor therapy for any disease or symptom. They are provided solely to support normal and healthy physiological processes of the human body.

HAIR ANALYSIS: If you opt to order a hair tissue mineral analysis, it **is not intended as a diagnosis** and does not replace the recommendations given by your medical doctor.

COMMUNICABLE/INFECTIOUS DISEASES: Our clinic has implemented preventive measures to **reduce** the risk of spreading communicable, contagious, or infectious diseases, including, but not limited to Covid-19; it cannot eliminate all risk. Your signature below indicates **you understand the potential risks and choose to proceed with treatment**.

I have read, understand, and agree to the above policies:

X _____ _____

Patient or Legal Guardian Signature Date

_____

Printed Name

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Communication Consent

Patient Name: _____

Primary Phone Number: _____

❑ Only leave a **basic message** to call the clinic.

❑ Okay to leave a **detailed message** regarding instructions or response to questions.

Email address: _____

May we send **appointment reminders** to your email? ❑Yes ❑No
(Checking No means you will ***not*** get any appointment reminders from us.)

May we add you to our **email newsletter**? ❑Yes ❑No
(We will never spam or share your information – you may unsubscribe at any time.)

May we use **email to communicate** with you about your treatment, supplement instructions, answers to your questions, etc.? ❑Yes ❑No (Email is not HIPAA compliant.)

_____ _____
Signature of Patient or Legal Guardian Date

Authorization to Release Medical Information *(Optional)*

By signing below, I give permission to Three Wells Acupuncture Clinic, Inc. to release written or verbal health care information to the person(s) listed below as indicated: [check all that apply]

Name	Relationship	Phone	May schedule appts	May receive billing information	May receive info re: purchase and use of supplements	May receive any info re: treatments including all my health information
			❑ Yes	❑ Yes	❑ Yes	❑ Yes
			❑ Yes	❑ Yes	❑ Yes	❑ Yes
			❑ Yes	❑ Yes	❑ Yes	❑ Yes

I understand that this release form will stay in effect unless and until I revoke it in writing.

_____ _____
Signature of Patient or Legal Guardian Date