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Acupuncture & Herbal Medicine
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Date:_____

**CLIENT PROFILE**

**A note to our clients:** Please complete this profile as thoroughly as possible. This is a confidential record of your medical information and will not be released, except under the guidelines of the Notices of Privacy Practices. **Please include any copies of all labs & imaging related to your fertility completed within the last 12 months.**

Name: _____ Date of Birth: _____ Age: _____
Partner's Name: _____ Date of Birth: _____ Age: _____
Address: _____City: _____ State: _____ Zip: _____
Email: _____ Telephone (Mobile/Home): _____
Best telephone number/email to reach you for your consultation: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
How did you hear about us? _____
What goals do you have for your visit? _____
_____
_____
_____
Have you ever consulted providers in integrative medicine before? If yes, please describe what these were (nutritionist, acupuncturist, naturopathic doctor). _____
_____

**Please tell us about your recent fertility journey:**
For how long have you been trying to conceive? _____
Have you had any recent prenatal blood work, Ultrasound, Imaging, Genetic Screening, Hysterosalpingogram (HSG) or Endometrial Biopsy related to your fertility within the last 12 months? Y / N **(Include Copies)**
**Which of the following have you tried? (select all that apply)**
☐ Cycle charting & timed intercourse. For how long _____
What was the outcome?_____
Do you see clear signs of Ovulation? (mid-cycle BBT temperature shift, fertile mucus, quality and quantity, cervical position, etc) _____
_____
_____
☐ Medication-supported cycles. How many cycles? _____
Which medication/dose was used? _____
What was the outcome? _____
☐ IUI How many cycles? _____ Which medication/dose was use _____
What was the outcome? _____
☐ IVF How many cycles? _____ Which medication/dose was use_____
What was the outcome? _____
☐ Donor Eggs ☐ Donor Sperm ☐ Other _____
Have you received a diagnosis for your infertility to date? If yes, please describe: _____
_____
_____
_____

**For this section, please have each partner fill out their information.**

Occupation: _____ Hours of work p/week: _____ Is your occupation stressful? Y / N

Sleep: Hours/night: _____. Sleep quality: ☐ Great ☐ Trouble falling asleep ☐ Trouble Staying Asleep

Daily Water Intake: _____ Source: _____

Do you exercise regularly? Y / N What type? _____How frequently? _____

Do you follow any particular diet regimens or restrictions? If so, please describe. _____

_____

_____

**Pregnancy History:**

Number of prior pregnancies: _____

If you have been pregnant before (even with prior partners), please list the outcomes of those pregnancies.

| **Date of pregnancy** (month / year) | **Outcome** (i.e. live birth, stillbirth, miscarriage, abortion, ectopic, D&C, other) | **Details** (timing of loss and cause, if known, age of living child, etc) |
|---|---|---|
| | | |
| | | |
| | | |

**Your Cycle:**

Age of 1st Period (Menarche) ?_____

Are your cycles. ☐ Regular ☐ Irregular ☐ I have not had a cycle for >6 months.

Typical Length (days between one cycle and the next) _____. Days of bleeding: _____

Do you get cramps or pain? Y / N Location? _____

Nature of Pain: ☐ Before ☐ During ☐ After Menses

Amount of flow: ☐ Light ☐ Moderate ☐ Heavy ☐ Explain: _____

Color of Flow: ☐ Light red ☐ Red ☐ Dark red ☐ Purplish ☐ Brown ☐ Black

Do you get Cloths: Y / N Color?_____

**Other symptoms related to Menses:**

☐ Breast tenderness
☐ Bleeding or spotting between periods
☐ Acne during period
☐ Discharge
☐ Nausea
☐ Increase appetite
☐ Constipation
☐ Night sweats
☐ Mood swings
☐ Hot flashes
☐ Headaches/Migraines
☐ Diarrhea
☐ Insomnia
☐ Other: _____

Do you get yeast infections or UTI's often? Y / N

Date of last GYN/Paps Smear exam: _____ Results: _____

Are you OR have you been on Birth Control? Y / N Type: _____

Since when / How long? _____ Date when you stopped birth control: _____

Have you noticed any changes in your cycle? Y / N Explain:_____

How long have you been trying to conceive? _____

Do you have OR have you been diagnosed with:

☐ PCOS
☐ Pelvic Inflammatory disease
☐ Fibrocystic Breast
☐ Salpingitis / Blocked Tubes
☐ PMS
☐ PMDD
☐ Endometriosis
☐ Uterine Fibroids
☐ Uterine Polyps
☐ Ovarian Cyst
☐ Pelvic Adhesions
☐ Other: _____

**Please tell us a bit about your health:**

Hospitalizations: _____

Serious injuries/chronic illnesses: _____

_____

Current health concerns (other than fertility): _____

_____

_____

Please indicate any significant illnesses you or a blood relative (Grandparent, Parent, Sibling) have had:

| Illness | You | Your Relative | Approx Date |
|---|---|---|---|
| Alcohol / Drug abuse | | | _____ |
| Allergies / Asthma | | | _____ |
| Anemia | | | _____ |
| Arthritis | | | _____ |
| Diabetes | | | _____ |
| Cancer | | | _____ |
| Depression/ Anxiety | | | _____ |
| Diabetes | | | _____ |

| Illness | You | Your Relative | Approx Date |
|---|---|---|---|
| Eczema | | | _____ |
| Headaches | | | _____ |
| Liver Disease/ Hepatitis | | | _____ |
| High Blood pressure | | | _____ |
| Heart Disease | | | _____ |
| Infectious Disease | | | _____ |
| Other | | | _____ |

**Do you use any of the following, and with what frequency?**

☐ Alcohol. Freq. _____

☐ Caffeine. Freq. _____

☐ Marijuana. Freq. _____

☐ Tobacco. Freq. _____

☐ Other recreational drugs: _____

_____

**List any medications and supplements you are currently taking (continue on back if necessary).**

| Medicine / Supplement | Dosage | Reason | How Long |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Do you have any allergies? (Drug, food, etc) If Yes, please describe reaction: _____

_____

_____

Have you been diagnosed with an Auto-Immune disease? Y / N Explain: _____

How's your sexual Energy / Libido? ☐ Low ☐ Normal ☐ High

Do you use vaginal lubricants? Y / N Do you experience pain during intercourse (Dyspareunia)? Y / N

Do you experience excessive hair loss? Y / N Have you noticed discharge from your nipples? Y / N

Did your mother, grandmother or siblings had any difficulty in getting pregnant? Y / N

How old was your mother when she conceived you?_____

Have you been exposed to environmental toxins? Y / N Are you currently taking steroids? Y / N

**ABOUT HIM:**

**For this section, please have each partner fill out their information.**

Occupation: _____ Hours of work p/week: _____ Is your occupation stressful? Y / N

Sleep: Hours/night: _____. Sleep quality: ☐ Great ☐ Trouble falling asleep ☐ Trouble Staying Asleep

Daily Water Intake: _____ Source: _____

Do you exercise regularly? Y / N What type? _____How frequently? _____

Do you follow any particular diet regimens or restrictions? If so, please describe. _____

_____

_____

**Reproductive History:**

Do you have children? Y / N

If you have children (even with prior partners), please list the outcomes of those pregnancies (i.e. Natural pregnancies, miscarriages, medicated/controlled cycle, IUI, IVF, miscarriage, abortions, genetic abnormalities, other). _____

_____

**Please tell us about your recent fertility journey:**

For how long have you been trying to conceive? _____

Have you had any recent Hormonal Blood work, Ultrasound, Imaging, Genetic Screening, Semen analysis or DNA fragmentation test, related to your fertility within the last 12 months (*Please Include Copies*)? Y / N

Results: _____

_____

Have you received a diagnosis for your infertility to date? If yes, please describe: _____

_____

_____

_____

Date of last prostate check up: _____ PSA Results: _____

Manual prostate exam results:_____ Lab Results: _____

Do you have frequent of urination? Y / N Color of Urine? _____ Odor: Y / N

**Symptoms related to Prostate: (check all that apply)**

| | | | |
|---|---|---|---|
| __Prostate Problems | __Delayed Stream | __Decrease Libido | __Premature Ejaculation |
| __Erectile Dysfunction | __Increase Libido | __Testicular Pain | __Decrease Force of stream |
| __Back Pain | __Groin Pain | __Incontinence | __Retention of Urine |
| __Other:_____ | | __Impotence | __BPH/Enlarge Prostate |

**Please tell us a bit about your health:**

Hospitalizations: _____

Serious injuries/chronic illnesses: _____

_____

Current health concerns (other than infertility): _____

_____

_____

List any medications and supplements you are currently taking (continue on back if necessary).

| Medicine / Supplement | Dosage | Reason | How Long |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Please indicate any significant illnesses you or a blood relative (Grandparent, Parent, Sibling) have had:

| Illness | You | Your Relative | Approx Date |
|---|---|---|---|
| Eczema | | | _____ |
| Headaches | | | _____ |
| Liver Disease/ Hepatitis | | | _____ |
| High Blood pressure | | | _____ |
| Heart Disease | | | _____ |
| Infectious Disease | | | _____ |
| Other | | | _____ |

| Illness | You | Your Relative | Approx Date |
|---|---|---|---|
| Alcohol / Drug abuse | | | _____ |
| Allergies / Asthma | | | _____ |
| Anemia | | | _____ |
| Arthritis | | | _____ |
| Diabetes | | | _____ |
| Cancer | | | _____ |
| Depression/ Anxiety | | | _____ |
| Diabetes | | | _____ |

**Do you use any of the following, and with what frequency?**

☐ Alcohol. Freq. _____
☐ Caffeine. Freq. _____
☐ Marijuana. Freq. _____
☐ Tobacco. Freq. _____
☐ Other recreational drugs: _____
_____

Do you have any allergies? (Drug, food, etc) If Yes, please describe reaction: _____
_____

Have you been diagnosed with an Auto-Immune disease? Y / N Explain: _____

How's your sexual Energy / Libido? ☐ Low ☐ Normal ☐ High

Have you had a Semen Analysis or DNA fragmentation test? Y / N

Results: _____

Did your parents, grandparents or siblings had any difficulty in getting pregnant? Y / N

How old was your mother when she conceived you?_____

Have you been exposed to environmental toxins? Y / N

Are you currently taking steroids? Y / N

Are you constantly exposed to radiation or heat? Y / N

Do you wear tight-fitting underwear? Y / N

## Cancelation and Payment Policy

**We kindly ask all new patients to read the following and provide a signature where indicated.**

### Payment Policy

All Services and herbs are payable at the time they are received. You are responsible for co-pays, deductibles and cost of treatment at the time of service.
Many insurance policies do cover acupuncture but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductibles and percentage of coverage for acupuncture care. We will provide you with the proper documentation necessary for individual reimbursement by your Insurance.

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### Cancelation Policy

Please contact us via phone or email **AT LEAST 24 hours** prior to your scheduled appointment date and time to avoid cancellation fees.

We reserve an appointment time for you and ask that you call us if you cannot keep your appointment. In consideration of other folks who may be on a waiting list for appointments, we ask that you give us at least 24 hours' notice in advance of an appointment that you'll not be able to keep. All appointments that are cancelled with less than 24 hours notice, or are missed altogether without letting us know, will be charged a $50 fee payable at the next visit. We do also recognize that emergencies happen, and would be happy to consider these on an individual basis, or course. Thanks for understanding and in doing so, helping us to keep our fees as low as possible.

We thank you for your consideration and cooperation.

I the patient acknowledge I have read and fully understand the above policies and that I agree with the policies and fees. All of my questions have been answered.

_____ _____

Signature of patient or person authorized to consent Date