

ACUPUNCTURE CENTER
for Reproductive Health

254 Route 202/206 Pluckemin, NJ 07978 (908)719-1362 www.acrh.net

Name _____
Address _____
City _____ State _____ Zip _____
Cell # _____ Home # _____ Work # _____
Birth date _____ Age _____ Height _____ Weight _____ Sex _____
Marital status _____ Number & ages of children _____
Occupation _____
Email _____ Would you like to receive our newsletter? Y N
Personal physician _____
Date of last physical examination _____
In emergency Contact _____ Relationship _____ Phone _____
Referred by _____
Have you ever had **acupuncture** before? Y N
How did you hear about our clinic? _____

MAJOR COMPLAINT (Reason for Visit)

How long have you had this complaint? _____

Have you ever received treatment for this condition? If yes, when? By whom?

What was the diagnosis? What were the results of the treatment?

Has the condition gotten: Better Worse About the same

What makes it better?

What makes it worse?

Describe what caused it or how it started:

FAMILY MEDICAL HISTORY:

- Cancer Diabetes High or Low Blood Pressure Heart Trouble TB Allergies Kidney Disease
 Epilepsy Asthma Liver Disease Ulcers Sinus Problems Eye Disease Arthritis Alcoholism
 Spinal Problems Mental Disorders Drug Addiction Other _____

PERSONAL MEDICAL HISTORY

(Include date) Major Surgeries - Illnesses - Diseases - Accidents

CONTAGIOUS DISEASES

(Circle if you have or ever had one of the following):

- HIV + AIDS Hepatitis STD Herpes Other _____

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ALLERGIES

(Drugs, chemicals, food, animals, seasonal, etc.)

MEDICATIONS PRESENTLY TAKING:

EXERCISE:

Never Little Moderate Heavy Type of exercise _____

NEUROPSYCHOLOGICAL:

Happy **Easily irritable** **Difficulty expressing anger** Angry Cry easily Poor memory Tics
 Tremors Depression **Easily effected by stress** **Restless** Anxious Other _____

DIET (Typical Foods):

APPETITE:

Up and down Poor Good Hungry a lot Loss of taste Hunger with no desire to eat

Do you normally crave: Sweets Sour food Salty food Bitter food Spicy food

WEIGHT:

Normal Underweight Overweight Recent gain Recent loss

ENERGY:

Up and down Low Normal Excess Low after eating **Heavy feeling in 4 limbs**

Tired in the afternoon Other _____

BODY TEMPERATURE:

Feel Warm/Hot often Flushed face Feel warmer late afternoon and night Sweat easily Night sweats

Feel cold often Warm palms Warm soles **Alternate chills and fever** Profuse perspiration Never sweats

Hate the cold Hate when it is windy Hate the heat Cold hands and feet Cold limbs Normal

Sweat on chest Other _____

DIGESTION:

Indigestion Bloating Heartburn Nausea Vomiting **Full feeling or distention** Belching/hiccupping

Abdominal pain or cramps Gas Difficulty digesting fatty or oily foods Bitter taste in mouth upon waking

Sticky/wet feeling in mouth Normal Other _____

BOWELS:

Loose stool **Diarrhea- foul smelling** Diarrhea- no smell Diarrhea upon waking Hemorrhoids Dry, hard

stool Constipation **Undigested food in stool** Pain or cramps **Mucous in stool** **Blood in stool** Use

laxatives Normal Other _____

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URINATION (three to four times per day is normal):

- Frequent Burning Bladder infections Urgency **Nighttime** Incontinence Cloudy Copious Scanty
 Dark yellow color Dribbling Pale/clear color Kidney stones or infections Normal Other _____

THIRST:

- Lack of thirst **Crave cold drinks** **Thirsty but no desire to drink** Prefer hot drinks Thirsty but likes to sip
fluid Excessive Normal Other _____

SLEEP:

- Difficulty falling asleep Lots of dreams Tired when get up in morning Nightmares Sleep too much
 Waking during the night Restless Wake very early Normal Other _____

HEADACHES - DIZZINESS:

- Headaches Migraines Vertigo Dizziness Motion sickness Poor balance Faint easily **Muzzy head**
 Poor memory Where are the headaches located? _____
 Does it happen at a particular time (before period, when stressed etc) _____

SKIN:

- Dry Hives Itching Oily Cystic Acne Red acne Bruise easily Rashes Damp Greasy
 Edema/swelling **Areas of numbness** Cuts heal slowly Normal Other _____

HAIR:

- Dry Oily Dandruff Falling out Early grey Normal Other _____

NAILS:

- Soft Spots Grow slowly Ridges and lines Purple Normal **Weak/Break easily** Pale
 Other _____

EYES:

- Blurry** Eyelids swollen Red Dry Itch **Poor night vision** Twitch Pain Color blindness
 Tear easily **Floaters** Dark circles under Normal Other _____

EARS:

- Poor hearing Ringing (high pitch) Ringing (low pitch) Discharges Ear aches Normal
 Other _____

NOSE:

- Stuffy nose Hay Fever Sneeze a lot Environmental sensitivity Clear runny mucous **Yellow mucous**
 Bleeding Loss of smell Blow nose a lot Sinusitis Rhinitis Normal Other _____

MOUTH & THROAT:

- Dry Gum problems Frequent colds Difficulty swallowing TMJ Feel lump in throat Chapped lips
 Mouth/tongue sores Normal Other _____

RESPIRATORY:

- Shortness of breath** Difficulty inhaling Difficulty exhaling Sighing Chest pain Dry cough
 Asthma Difficulty breathing Cough with phlegm Weak Voice Sneezing Cough with blood
 Tightness in chest Wheezing Normal Other _____

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CARDIOVASCULAR - CIRCULATION

- Diagnosed heart problems **Palpitations** Low blood pressure High blood pressure Bleed easily Facial swelling High cholesterol **Varicose veins** **Ankle/leg swelling** Chest pain Bruise easily **Hand swelling**
 Irregular heart beat Numbness in extremities Normal Other _____

PAIN:

- Low back Shoulder Muscle weakness Sciatica Hands or wrists Muscle cramps **Rib pain**
 Upper back Hips Muscle twitching or spasm Mid back Knees **Worse with Damp weather**
 Neck Foot or ankle Nerve Spine Arthritis Flank area Other _____

ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS?

***** FOR WOMEN ONLY *****

- Are you or might you be pregnant? YES NO MAYBE
Are you experiencing low sex drive? YES NO
Do you have regular pap tests? YES NO
Do you have facial hair or excess body hair? YES NO
Do you have vaginal dryness? YES NO
Do you have any nipple discharge? YES NO

MENSTRUAL CYCLE:

(Please check all that apply and explain as applicable)

Age started _____ Days of flow _____

Cycle Details:

- Always early (21 days or less) Always late (more than 35 days) Irregular Normal (approx. 28 days)
 Spotting between periods Spotting before period Bleeding stops and starts

Menstrual blood color:

- Dark color Light red/pink Purple Bright red Brown/black

Pelvic pain/cramps:

- None During menses Before menses After menses At ovulation During intercourse
 With bowel movements With urination Felt in external genital area

Pelvic pain/cramps are:

- Mild Moderate **Severe** Stabbing Dull/achy Feel better with heat Improve with rest
 Improve with exercise Better after passing clot Relieved by pressure Worsened by pressure
 Genital/uterine pain that is worse with cold or better with heat.

Blood flow is:

- Heavy flow Scanty flow Thick blood Thin watery blood Large clots (quarter size)
 Small clots (pea size) Dark colored clots Bright red clots

Premenstrual symptoms - mark with B (before), D (during) or A (after) period:

___ Water retention ___ Abdominal bloating ___ **Painful or tender breasts** ___ **Breast lumps** ___ Nausea
___ Emotional changes ___ Lump in throat feeling ___ Constipation ___ Diarrhea ___ Insomnia
___ Tightness in chest ___ Backache Other _____

VAGINAL DISCHARGES:

- Yellow** Thick Bad odor White Greenish Clear
Other _____

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FERTILE CERVICAL MUCUS

Lasts 1-3 days Scanty Absent

MENOPAUSE PROBLEMS?

Age menarche started _____

Explain symptoms: _____

PREGNANCIES:

Total number _____ Number of miscarriages _____ Number of children _____ Number of abortions _____

PREGNANCY OR CHILDBIRTH COMPLICATIONS:

GYNECOLOGICAL HISTORY AND OPERATIONS

WHAT METHOD OF BIRTH CONTROL DO YOU NOW USE?

WHAT METHOD OF BIRTH CONTROL HAVE YOU USED IN THE PAST?

***** FOR MEN ONLY *****

URO-GENITAL:

(Please check and explain as applicable)

Low sperm count Nocturnal emissions Premature ejaculation Prostate problems Sperm motility problems

Low sex drive Unusually high sex drive Erectile dysfunction

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1. IDENTIFYING INFORMATION

Name _____ DOB ____/____/____ Age ____
 Significant Other Name _____ DOB ____/____/____ Age ____
 Primary Care MD _____
 Physician Diagnosis _____
 Primary GYN or RE _____
 How long have you been attempting conception? _____ Marital Status _____

2. RACE (You)

- Caucasian Hispanic
 Asian African American
 Other (_____)

Significant Other

- Caucasian Hispanic
 Asian African American
 Other (_____)

ETHNICITY

- Ashkenazi Jew Southeastern Asian
 Greek/Italian

- Ashkenazi Jew Southeastern Asian
 Greek/Italian

3. PREGNANCY HISTORY

Times pregnant ____ Term births ____ Premature births ____ Miscarriages ____ Elective abortion ____
 Adopted children ____ Ectopic ____

Date	Months to conceive	Infertility Treatment	Complications
1.			
2.			
3.			

4. CONTRACEPTIVE USE

Type	Duration of use	Reason discontinued
1.		
2.		
3.		

5. OPERATIONS AND HOSPITALIZATIONS

Date	Diagnosis	Operation/Reason for Hospitalization	Physician
1.			
2.			
3.			

6. MEDICATIONS *List all prescriptions used during the past year*

Dates used	Dose and Frequency	Reason
1.		
2.		
3.		

7. ALLERGIES

Drug or substance	When	Reaction
1.		
2.		
3.		

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8. MENSTRUAL/HORMONAL

Height _____ Weight _____

Date of last two menstrual periods ____/____/____ and ____/____/____

If you have a hormonal disorder, please specify type and treatment: _____

Do you have or have you had? (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Hot flushes | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breast discharge | <input type="checkbox"/> Increased acne | <input type="checkbox"/> Increased facial/ body hair |
| <input type="checkbox"/> Visual disturbance | <input type="checkbox"/> Weight increase >10 lbs | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Poor sense of smell | <input type="checkbox"/> Weight loss > 10 lbs | <input type="checkbox"/> Autoimmune disease |
| <input type="checkbox"/> Chronic headache | <input type="checkbox"/> Special dietary habits | <input type="checkbox"/> Extraordinary stress |
| <input type="checkbox"/> Head trauma | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Psychiatric treatment |

Please explain a "Yes" answer: _____

9. GYNECOLOGIC / INFECTION

Do you have or have you had?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Pelvic infection | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Colitis/ enteritis | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Toxoplasmosis |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> Mycoplasma | <input type="checkbox"/> Cytomegalovirus (CMV) |
| <input type="checkbox"/> Pelvic adhesions | <input type="checkbox"/> Trichomonas | <input type="checkbox"/> Ureaplasma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cervicitis | <input type="checkbox"/> Vaginitis | <input type="checkbox"/> Genital warts | <input type="checkbox"/> Abnormal uterus shape |
| <input type="checkbox"/> Genital herpes | <input type="checkbox"/> Abnormal Pap | <input type="checkbox"/> Cryo (freezing) or surgery of the cervix | |
| <input type="checkbox"/> HIV + | <input type="checkbox"/> AIDS | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other _____ |

10. OTHER HISTORY

Your occupation: _____

Spouse's occupation: _____

Cigarettes: Yes No How many packs per day? _____

Alcohol: Yes No How many drinks per week? _____

Illicit drugs: Yes No Type and amount: _____

Caffeine Yes No Drinks per day: _____

Electric blanket use: Yes No

Toxic exposure: Yes No

Hot tub or sauna use: Yes No

Radiation exposure: Yes No

15. MALE HISTORY:

Medications: _____

Reproductive surgery: _____

Illnesses: _____

STDs: _____

Mumps Yes No

Testicular trauma Yes No

Smoker Yes No How many packs per day? _____

Impotence Yes No

Alcohol Yes No How many drinks per week? _____

Allergies: _____

Ejaculatory Disorder: _____

Seen urologist for infertility? Yes No

If yes: Physician name and location _____

Diagnosis: _____

Fathered a child/pregnancy with another woman? Yes No If yes, when? _____ years ago

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16. HISTORY OF FERTILITY THERAPY (Fill out, if applicable).

Have you been treated for infertility previously? Yes No

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

What drugs have you taken for infertility? Please check all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Clomid (Serophene) | <input type="checkbox"/> hCG Profasi | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Gonal F | <input type="checkbox"/> Progesterone | <input type="checkbox"/> Baby aspirin |
| <input type="checkbox"/> Follistim | <input type="checkbox"/> Lupron | <input type="checkbox"/> Heparin |
| <input type="checkbox"/> Repronex | <input type="checkbox"/> Microdose Lupron | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Pergonal | <input type="checkbox"/> Antagon | <input type="checkbox"/> Oral Contraceptives |
| <input type="checkbox"/> Fertinex | <input type="checkbox"/> Parlodel | <input type="checkbox"/> Other _____ |

Which of the following tests have you or your partner had performed? Please fill in latest results:

FSH _____

LH _____

Prolactin _____

Estradiol _____

DHEA-S _____

Testosterone _____

Progesterone _____

Hysterosalpingogram _____

Sonohystogram _____

Ultrasound _____

Laparoscopy, Hysteroscopy _____

Thyroid tests _____

Semen analysis _____

Antisperm antibodies _____

Varicocele repair _____

OTHER: _____

Have you ever undergone Artificial Insemination (IUI) Yes No

Have you ever undergone In Vitro Fertilization (IVF)? Yes No

If yes, how many? 1 2 3 4 or more

Did any lead to pregnancy? yes no Live birth miscarriage

Sperm was from: partner donor sperm

Eggs were from: self donor egg

How many eggs were retrieved with each cycle? _____

How many embryos survived up to the day of transfer? _____

Have you ever been on Clomid? Yes No

If yes, how many cycles? 1 2 3 4 or more

Outcome _____

Fertility Shots (natural cycle) Yes No

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Acupuncture Center for Reproductive Health
Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a certified acupuncturist at the Acupuncture Center for Reproductive Health (ACRH). I understand that acupuncturists practicing in the state of New Jersey are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioner.

I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy and heat lamp are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, vomiting, headache, diarrhea, rashes, hives, tingling of the tongue and the possible aggravation of symptoms existing prior to herbal treatment. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the ACRH as soon as possible.*

I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

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Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Acupuncture Center for Reproductive Health (hereafter noted as ACRH) for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at ACRH may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. ACRH is not required to agree to the restrictions that I may request. However, if ACRH agrees to a restriction that I request, the restriction is binding upon ACRH.

I have the right to revoke this consent, in writing, at any time except to the extent that ACRH has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review ACRH's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of ACRH. The Notice of Privacy Practices is also provided at the front desk. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and ACRH with respect to my identifiable health information.

ACRH reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

Signature of Patient or Authorized Representative

Date

Printed Name and Relationship

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Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (*e.g.* requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 908-719-1362.

Yours truly,

Candace Jania, L.Ac., C.H., FABORM
254 Route 202/206
(mail to: P.O. Box 83)
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908-719-1362