acupuncture center

Name ____
Address ____
City ______________________State__________Zip ____________
Preferred contact numbers ____________________ ____________________
Birth date __________ Age _____ Height ________ Weight ________
Sex listed w/health insurance: □ Female □ Male Identifying Gender ____________
Marital status ______ Number & ages of children ____________________
Occupation ____
Email______________ Would you like to receive our newsletter & email reminders? Y □ N □
Personal physician ____
In emergency Contact ______________ Relationship ________ Phone ____________
Have you ever had **acupuncture** before? Y □ N □
How did you hear about our clinic/referred by? ____________________

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:

____

____

PERSONAL MEDICAL HISTORY
(Include date) Major Surgeries - Illnesses - Diseases - Accidents

____

____

____

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

SUPPLEMENTS/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 ______________

acupuncture
center

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 ☐ Earaches ☐ 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 ___________________

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 heartbeat □ 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 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
Surgery/Varicocele repair ___________________________
Other ___________________________________

* * * * * * * 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

acupuncture center

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 ___________________________

FERTILE CERVICAL MUCUS
☐ Lasts 1-3 days ☐ Scanty ☐ Absent

MENOPAUSE PROBLEMS?
Age menarche started ________

Explain symptoms:
____
____

PREGNANCIES:
Total number ______ Number of miscarriages _____ Number of births to term _____

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?

acupuncture center

1. IDENTIFYING INFORMATION

Name ______________________________________ DOB ____/____/____ Age _______

Physician Diagnosis ____

Primary GYN or RE ____

How long have you been attempting conception? _____________________________________

☐ Married ☐ Divorced ☐ Partner ☐ Single

2. PREGNANCY HISTORY

Times pregnant _____ Term births _____ Premature births _____ Miscarriages _____

Elective abortion _____ Adopted children _____ Ectopic _____

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

3. MENSTRUAL/HORMONAL

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

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

Please explain a "Yes" answer: ____

4. GYNECOLOGIC/INFECTION

Do you have or have you had?

☐ Pelvic infection
☐ Chlamydia
☐ Endometriosis
☐ Pelvic adhesions
☐ Cervicitis
☐ Genital herpes
☐ HIV +
☐ Appendicitis
☐ Colitis/ enteritis
☐ Uterine fibroids
☐ Trichomonas
☐ Vaginitis
☐ Abnormal Pap
☐ AIDS
☐ Gonorrhea
☐ Syphilis
☐ Mycoplasma
☐ Ureaplasma
☐ Genital warts
☐ Cryo (freezing) or surgery of the cervix
☐ Hepatitis
☐ Ovarian cysts
☐ Toxoplasmosis
☐ Cytomegalovirus (CMV)
☐ Tuberculosis
☐ Abnormal uterus shape
Other_______________

5. OTHER HISTORY

Your occupation ____

Partner's occupation if applicable ____

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

14 Church Street, Basking Ridge, NJ 07920 ▯ Mail to: PO Box 200, Liberty Corner, NJ 07938 ▯
(908)719-1362 ▯ www.njacucenter.com

acupuncture center

6. MALE HISTORY:

Using donor sperm? ______________________ If yes, skip to #7.
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 ____
If yes: Physician name and location_____________________________
Diagnosis____
Motility __________ Morphology __________Count __________ Other __________
Fathered a child/pregnancy with another woman? ☐ Yes ☐ No If yes, when? _____years ago

7. 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:

☐ Clomid (Serophene)	☐ hCG	☐ Antibiotics
☐ Gonal F	☐ Progesterone	☐ Baby aspirin
☐ Follistim	☐ Lupron	☐ Heparin
☐ Repronex	☐ Microdose Lupron	☐ Steroids
☐ Pergonal	☐ Antagon	☐ Oral Contraceptives
☐ Fertinex	☐ Parlodel	☐ Other ______________

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

AMH ______________________________
FSH ______________________________
LH ______________________________
Prolactin ______________________________
Estradiol ______________________________
DHEA-S ______________________________
Testosterone ______________________________
Progesterone ______________________________
Hysterosalpingogram ______________________________
Sonohystogram ______________________________
Laparoscopy, Hysteroscopy ______________________________
Thyroid tests ______________________________
Other ______________________________

acupuncture center

Have you ever undergone Artificial Insemination (IUI) ☐ Yes ☐ No

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

Did any lead to pregnancy? ☐ Yes ☐ No ☐ Live birth ☐ Miscarriage

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/Letrazol? ☐ Yes ☐ No

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

Outcome ____

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: _______________

14 Church Street, Basking Ridge, NJ 07920 ▯ Mail to: PO Box 200, Liberty Corner, NJ 07938 ▯
(908)719-1362 ▯ www.njacucenter.com

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

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
Michael Gonzales, L.Ac.
Hannah Ciraco, L.Ac.
14 Church Street
Basking Ridge, NJ 07920
(mail to: PO Box 200, Liberty Corner, NJ 07938)
(908) 719-1362