



IVELISSE DEJONGH, A.P.  
 2929 SW 3RD AVE. SUITE 610, MIAMI FL, 33129  
 PHONE: 305-677-3214 FAX: 786-329-5692 Email: admin@miamiacupunctureclinic.com

**Men's Fertility**

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

Last name /		First name /		Circle: Mr. Dr.
Birth date /		Age /		Circle # of preferred contact
Address /			Phone (home) /	
City /			Phone (work) /	
Province /		Postal Code /		Phone (cell) /
Email /			Occupation /	
Height /		Weight /		Emergency Contact /

Reason for Visit /	Have you had Acupuncture before? Yes No
	Chinese herbal medicine? Yes No

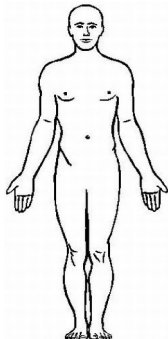
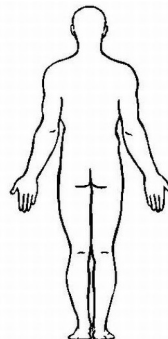
Family Physician name /	Family Physician phone /
Western Medical diagnosis (if applicable) /	

Other medical treatment received (circle) / Fertility clinic Physiotherapy Massage Naturopathy Chiropractic Other:

Please indicate with a 'P' (past) 'C' (current) 'F' (family) if any of the conditions below apply:

<input type="checkbox"/>	Heart conditions	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Deep vein thrombosis	<input type="checkbox"/>	Neurological condition	<input type="checkbox"/>	Spinal or head injury
<input type="checkbox"/>	Respiratory condition	<input type="checkbox"/>	Kidney disorder	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	Sprain/strain/fracture	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Headaches/migraines
<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Dizziness/fainting	<input type="checkbox"/>	Contagious illness
<input type="checkbox"/>	Skin condition	<input type="checkbox"/>	Digestive problems	<input type="checkbox"/>	Haemophiliac	<input type="checkbox"/>	Wear a pacemaker
<input type="checkbox"/>	Lung condition	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>		<input type="checkbox"/>	Upcoming surgeries

On the figures below, please circle the areas of concern/pain;

Sensations/pain characteristics (circle):  
 Sharp Burning Moving Tingling Dull Severe  
 Stabbing Shooting Throbbing Numbness

What relieves the pain (ice, rest, activity, massage, heat)?  
 \_\_\_\_\_

What aggravates the pain (weather, heat, cold, rest, activity...)?  
 \_\_\_\_\_

Please list any prescription medication or over the counter drugs currently taking:

1. _____	2. _____
3. _____	4. _____
5. _____	6. _____

Please list herbal medicine and other supplements currently taking:

1. _____	2. _____
3. _____	4. _____
5. _____	6. _____

Please list any allergies (food, drugs, environmental, etc.):

1. _____	2. _____
3. _____	4. _____

Have you been hospitalized and/or treated for any infectious/serious conditions or surgeries? If yes, briefly explain for what condition or reasons and the year (below).

\_\_\_\_\_

Do you use the following? If so how often? Cigarettes: \_\_\_\_\_ Alcohol: \_\_\_\_\_ Drugs: \_\_\_\_\_ Coffee: \_\_\_\_\_ Pop: \_\_\_\_\_

Do you participate in the following physical activities? If so, please indicate how often:			
Yoga:	Running:	Fitness Class:	Gym:
Biking:	Swimming:	Walking:	Other:

**Please print, complete, and email in forms before your initial appointment. Thank you.**



IVELISSE DEJONGH, A.P.  
 2929 SW 3RD AVE. SUITE 610, MIAMI FL, 33129  
 PHONE: 305-677-3214 FAX: 305-433-7752 Email: admin@miamiacupunctureclinic.com

How did you hear about DeJongh Acupuncture Clinic? (Internet, Friend, Doctor, Fertility Clinic, Seminar, Magazine, TV, News) \_\_\_\_\_

**For each symptom below that you currently have, rate its severity from 1-5 (5 being worst). Leave blank if N / A.**

<p><b>Gan</b></p> <p><input type="checkbox"/> Irritability / frustration / impatient</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Stress</p> <p><input type="checkbox"/> Emotional eating</p> <p><input type="checkbox"/> Unfulfilled desires</p> <p><input type="checkbox"/> Visual problems / floaters</p> <p><input type="checkbox"/> Blurred vision / poor night vision</p> <p><input type="checkbox"/> Red / dry / itchy eyes</p> <p><input type="checkbox"/> Headaches / Migraines</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Feeling of lump in throat</p> <p><input type="checkbox"/> Muscle twitching / spasm</p> <p><input type="checkbox"/> Neck / shoulder tension</p> <p><input type="checkbox"/> Brittle nails</p> <p><input type="checkbox"/> Sighing</p> <p><input type="checkbox"/> Sensation or pain under rib cage</p> <p><input type="checkbox"/> Genital itching / pain / rashes</p> <p><b>Xin</b></p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Chest pain / tightness</p> <p><input type="checkbox"/> Insomnia / sleep problems</p> <p><input type="checkbox"/> Restless / easily agitated</p> <p><input type="checkbox"/> Vivid dreams</p> <p><input type="checkbox"/> Lack of joy in life</p> <p><input type="checkbox"/> Forgetful</p> <p><input type="checkbox"/> Aversion to heat</p> <p><input type="checkbox"/> Bitter taste in mouth</p> <p><input type="checkbox"/> Tongue / mouth ulcers / cankers</p>	<p><b>Shen</b></p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Bladder infection</p> <p><input type="checkbox"/> Lack of bladder control</p> <p><input type="checkbox"/> Wake to urinate</p> <p><input type="checkbox"/> Feel cold easily</p> <p><input type="checkbox"/> Cold hands / feet</p> <p><input type="checkbox"/> Night sweats / hot flushing</p> <p><input type="checkbox"/> Low sex drive</p> <p><input type="checkbox"/> High sex drive</p> <p><input type="checkbox"/> Loss of head hair</p> <p><input type="checkbox"/> Hearing problems</p> <p><input type="checkbox"/> Crave salty food</p> <p><input type="checkbox"/> Fear</p> <p><input type="checkbox"/> Poor long term memory</p> <p><input type="checkbox"/> Ankle swelling</p> <p><input type="checkbox"/> Tinnitus</p> <p><b>Fei</b></p> <p><input type="checkbox"/> Dry cough</p> <p><input type="checkbox"/> Cough with Phlegm</p> <p><input type="checkbox"/> Nasal discharge / drip</p> <p><input type="checkbox"/> Sinus infection / congestion</p> <p><input type="checkbox"/> Itchy / painful throat</p> <p><input type="checkbox"/> Dry mouth / throat / nose</p> <p><input type="checkbox"/> Skin rashes / hives</p> <p><input type="checkbox"/> Snoring</p> <p><input type="checkbox"/> Grief / sadness</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Allergies / asthma</p> <p><input type="checkbox"/> Weak immune system</p> <p><input type="checkbox"/> Alternate fever / chills</p>	<p><b>Pi</b></p> <p><input type="checkbox"/> Heaviness in the head / body</p> <p><input type="checkbox"/> Fatigue / after eating</p> <p><input type="checkbox"/> Difficult getting up in morning</p> <p><input type="checkbox"/> Water retention</p> <p><input type="checkbox"/> Muscular tired / weak</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Unusual bleeding (stool, nose, etc)</p> <p><input type="checkbox"/> Bad breath</p> <p><input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> Increased appetite</p> <p><input type="checkbox"/> Crave sweets</p> <p><input type="checkbox"/> Poor digestion</p> <p><input type="checkbox"/> Nausea / vomiting</p> <p><input type="checkbox"/> Bloating / gas</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Loose stool</p> <p><input type="checkbox"/> Alternate constipation / loose</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Intestinal pain / cramping</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Pensive / over-thinking</p> <p><input type="checkbox"/> Overweight</p> <p><input type="checkbox"/> Foggy mind</p> <p><input type="checkbox"/> Yeast infection</p> <p><input type="checkbox"/> Aversion to cold</p> <p><input type="checkbox"/> Cold nose</p> <p><input type="checkbox"/> Increased thirst</p> <p><input type="checkbox"/> Prefer warm / cold drinks</p> <p><input type="checkbox"/> Sweat easily</p>
---	--	--

Besides fertility, list your main health concerns in order of importance to you:	1.	2.
	3.	4.

On a scale of 1-10, how would you rate your daily energy level (10 being best)?

Are your bowel movements regular? How many times per day/week? Are they formed, loose, constipated, or do they alternate from loose to difficult to pass?

Do you experience urinary frequency, urgency, burning, dribbling, retention? What colour/shade of yellow is it? Do you have a history of urinary tract infections?

How many glasses of water do you drink in a day?

How many times in your life have you taken Antibiotics (approx. #)? How many times have you taken oral steroids? Please describe in general what you eat, and what do you crave? (sweet, spicy, salty, organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.)

Do you have trouble falling asleep? Are you a light sleeper? How many hours per night? Do you have vivid dreams? If so, what are they about? Wake and have difficulty falling back to sleep?

If you were asked to describe yourself from an emotional standpoint, what would you say (i.e. irritable, worrier, anxious, sad, impatient, stressed, etc.)?

**Please print, complete, and email in forms before your initial appointment. Thank you.**



IVELISSE DEJONGH, A.P.  
 2929 SW 3RD AVE. SUITE 610, MIAMI FL, 33129  
 PHONE: 305-677-3214 FAX: 305-433-7752 Email: admin@miamiacupunctureclinic.com

Name of spouse or partner: \_\_\_\_\_

How long have you and your partner been trying to conceive? \_\_\_\_\_

Are you currently undergoing assisted reproductive treatments (IUI, IVF, ICSI, superovulation, etc.)? \_\_\_Yes \_\_\_No

If yes, at what fertility clinic? \_\_\_\_\_

How is your sexual energy/libido?	___ Below normal	___ Normal	
Have you had a recent physical exam?	___ Yes	___ No	
Do you or did you have an undescended testicle?	___ Yes	___ No	
Have you ever been diagnosed with a varicocele?	___ Yes	___ No	
Have you ever had any urologic surgeries?	___ Yes	___ No	
Have you experienced erectile dysfunction?	___ Yes	___ No	
Have you experienced difficulty ejaculating?	___ Yes	___ No	
Have you been exposed to any environmental toxins or hormones?	___ Yes	___ No	
Have you experienced any penile discharge?	___ Yes	___ No	
Do you regularly experience nocturnal emission?	___ Yes	___ No	
Do you have high cholesterol?	___ Yes	___ No	
Have you had a high fever in the past 6 months?	___ Yes	___ No	
Do you currently have any prostate conditions?	___ Yes	___ No	
Do you have or have you ever had urinary infections or STDs?	___ Yes	___ No	
Have you ever taken testosterone supplements/drugs?	___ Yes	___ No	
Have you recently had your testosterone levels checked?	___ Yes	___ No	
Have you been diagnosed with small or soft testes?	___ Yes	___ No	
Have you been checked for a blockage of your reproductive tract?	___ Yes	___ No	
Have you had any fertility testing?	___ Yes	___ No	
If yes, what was your sperm count?	___ Low	___ Normal	Count: _____
What was the sperm motility?	___ Low	___ Normal	Notes: _____
What was the sperm morphology?	___ Abnormal	___ Normal	Notes: _____

Other comments:



IVELISSE DEJONGH, A.P.  
 2929 SW 3RD AVE. SUITE 610, MIAMI FL, 33129  
 PHONE: 305-677-3214 FAX: 305-433-7752 Email: admin@miamiacupunctureclinic.com

Occupation: In the space provided, please explain what you do, duties involved, and stress levels.

Personal Stress: What are the personal and professional stresses in your life?

Hobbies and Passions: What makes you happy?

What health-related goals would you like to achieve with your treatment at DeJongh Acupuncture Clinic?

What do you think is the cause of your fertility issues, and what would fix them?

*Circle, highlight, or underline the terms or phrases in the right column that accurately describe aspects of your character. Please take some time, think critically, and be honest.*

Kidney yang vacuity	Lack of will power or assertion that propels and targets the major episodes of life Fear Paralyzed by the unknown Passive Easily controlled by others Take blame Feel guilty Large sense of responsibility Sexual anxiety
Kidney yin vacuity	Irritable Fidgety Jumpy Chatty Effort to conceal anxiety Flighty Restless Forget names Hastily say unintended words Lack of tranquility Dread of death Sexual anxiety
Liver qi stagnation	Feel stuck or frustrated Hit a wall Blocked Emotional tension Stress Easily annoyed Grumpy
Lower jiao damp-heat	The possibility of transformation becomes the burden of unfinished business Excess worry Feel trapped by many good possibilities Many unfinished projects Cannot make clear distinctions Care for others but not self
Heart spleen qi & blood vacuity	Forgetful Anxiety with situations and people Shyness Withdrawing Feel vulnerable Awkwardness Forget the words you are meaning to say Forget routine things Restless Tightness Jumpy Poor self-esteem General inappropriate presence of tension Poor motivation Lack of excitement Bored Despondent Avoid activities that were once pleasurable Not interested in the world Not engaged in creative transformation

**Please print, complete, and email in forms before your initial appointment. Thank you.**



IVELISSE DEJONGH, A.P.  
2929 SW 3RD AVE SUITE 610, MIAMI FL, 33129  
PHONE: 305-677-3214 FAX: 305-433-7752 Email: admin@miamiacupunctureclinic.com

## OFFICE AND FINANCIAL POLICIES

**FEES:** The fees charged in this office are comparable to those charged by other healthcare providers in these areas, with similar qualifications. We accept cash, credit cards and personal checks. Please note there is a \$25 charge for checks with insufficient funds.

**PACKAGE AGREEMENTS:** The packages that are offered in this office are at a discounted rate from the price per treatment. **The packages are non-refundable and can not be shared.** If you suspend or terminate your care at any time, your portion of all charges on your package agreement will be immediately due and charged to this office to the credit card that's on file.

**INSURANCE COVERAGE:** Many insurance policies cover Acupuncture care, 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. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

**VOLUNTARY TERMINATION OF CARE:** If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

## APPOINTMENT POLICY

Welcome to DeJongh Acupuncture Clinic. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy.

Many of our clients are pleased to find out that we are usually on time. This is because **a treatment room has been reserved for you**, whereas most medical offices overbook by appointing several patients at the same time. That kind of scheduling provides the practitioner with a steady flow of patients but does not respect the patient's time. Occasionally, there is a problem with patients who are not used to staying on schedule themselves. With that in mind, **if you are going to be more than 15 minutes late, please call to confirm availability. If arriving late to appointment, patient will receive a treatment for remainder of the allotted time.**

## CANCELLATION POLICY

As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance for any reschedule or cancellations in order to avoid the cancellation fee. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours. **No emails or rescheduling notice will be accepted as cancellation, you must call the office to notify one of our staff members or leave a detailed voicemail.**

**A valid credit card must be on file for all Booked appointments. For any cancellations or no show given less than 24 hours which will be charged the full price of treatment scheduled as a cancellation fee and consultations will inquire a \$100 fee.**

\_\_\_\_\_  
Patient's name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's signature



IVELISSE DEJONGH, A.P.  
2929 SW 3RD AVE SUITE 610, MIAMI FL, 33129  
PHONE: 305-677-3214 FAX: 305-433-7752 Email: admin@miamiacupunctureclinic.com

### Patient Information Release Request Form

I, \_\_\_\_\_ (please print name) understand that as part of DeJongh Acupuncture Clinic's effort to provide me with the highest standard of integrated care, they may consult freely with other physicians and healthcare professionals, whose care I am under, regarding any of my medical treatments or relevant information. This could include the exchange of both verbal and written communications (including lab work).

I give full consent so that DeJongh Acupuncture Clinic may share personal information and my confidential treatment plan with my other healthcare providers to better my care. \_\_\_\_\_  
(Initial)

*(to be filled out by your DeJongh Acupuncture Clinic practitioner)*

The following is an authorization to provide DeJongh Acupuncture Clinic with the following information:

- All recent lab work results
- All medical records
- All semen tests
- Other: \_\_\_\_\_

Medical Services Plan (MSP) #: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Clinic Name: \_\_\_\_\_

Clinic Phone #: \_\_\_\_\_ Clinic Fax #: \_\_\_\_\_

I am nineteen years of age or older:

- Yes
- No

Client/Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent or guardian (if applicable): \_\_\_\_\_

Thank you for your prompt attention to this request. Please send information via email to admin@miamiacupunctureclinic.com or by fax to 786-329-5692. If you have any questions, please feel free to contact us.

DeJongh Acupuncture Clinic.

**Please print, complete, and email in forms before your initial appointment. Thank you.**



IVELISSE DEJONGH, A.P.  
2929 SW 3RD AVE SUITE 610, MIAMI FL, 33129  
PHONE: 305-677-3214 FAX: 305-433-7752 Email: admin@miamiacupunctureclinic.com

## Notice of Patient Privacy

### Health Insurance Portability & Accountability Act (HIPPA)

DeJongh Acupuncture Clinic is dedicated to preserving your personal health information. We are required, by law, to protect your personal medical information and to provide you with a notice describing how your medical information may be used, disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you and the related administrative activities supporting your treatment. We may be required by law, to use and disclose your medical information for other purposes without your consent or authorization. You are provided the right to request and receive a copy of your medical information that we maintain, amend or correct that information, obtain an accounting and/or disclosure of your medical information, and/or complain if you think, your rights have been violated in any way.

We have available, a detailed, NOTICE OF PRIVACY PRACTICES, which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The effective date, at the bottom of this page, indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE, in effect. If you have not received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

If you have any questions or concerns about the NOTICE or your medical information, please contact DeJongh Acupuncture Clinic at (305) 677-3214. You may also send a write complaint to the US Department of Health and Human Services.

\_\_\_\_\_  
Patient's name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's signature