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

Women's Fertility

Date:

Last name / First name / Circle: Ms. Mrs. 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:

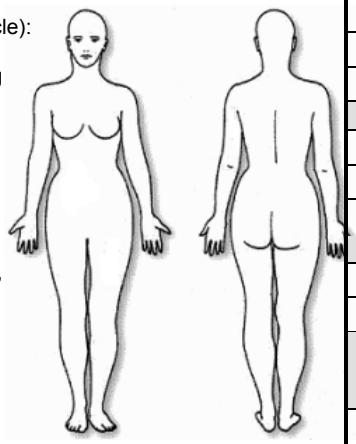
	Heart conditions		Stroke		High blood pressure		Low blood pressure
	Diabetes		Deep vein thrombosis		Neurological condition		Spinal or head injury
	Respiratory condition		Kidney disorder		Cancer		Hepatitis
	HIV / AIDS		Sprain/strain/fracture		Osteoporosis		Headaches/migraines
	Jaw pain		Arthritis		Dizziness/fainting		Contagious illness
	Skin condition		Digestive problems		Haemophiliac		Wear a pacemaker
	Lung condition		Epilepsy		Possibility of pregnancy		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:

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

If referred by current patient, we would like to thank your friend for the referral

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

Gan
___ Irritability / frustration / impatience
___ Depression
___ Stress
___ Emotional eating
___ Unfulfilled desires
___ Visual problems / floaters
___ Blurred vision / poor night vision
___ Red / dry / itchy eyes
___ Headaches / migraines
___ Dizziness
___ Feeling of lump in throat
___ Muscle twitching / spasm
___ Neck / shoulder tension
___ Brittle nails
___ Sighing
___ Sensation or pain under rib cage
___ PMS
___ Genital itching / pain / rashes

Xin
___ Palpitations
___ Chest pain / tightness
___ Insomnia / Sleep problems
___ Restless / easily agitated
___ Vivid dreams
___ Lack of joy in life
___ Forgetful
___ Aversion to heat
___ Bitter taste in mouth
___ Tongue / mouth ulcers / cankers

Shen
___ Frequent urination
___ Bladder infection
___ Lack of bladder control
___ Wake to urinate
___ Feel cold easily
___ Cold hands / feet
___ Night sweats / hot flushing
___ Low sex drive
___ High sex drive
___ Loss of head hair
___ Hearing problems
___ Crave salty food
___ Fear
___ Poor long term memory
___ Ankle swelling
___ Tinnitus

Fei
___ Dry cough
___ Cough with phlegm
___ Nasal discharge / drip
___ Sinus infection / congestion
___ Itchy / painful throat
___ Dry mouth / throat / nose
___ Skin rashes / hives
___ Snoring
___ Grief / sadness
___ Shortness of breath
___ Allergies / asthma
___ Weak immune system
___ Alternate fever / chills

Pi
___ Heaviness in the head / body
___ Fatigue / after eating
___ Difficult getting up in morning
___ Water retention
___ Muscular tired / weak
___ Bruise easily
___ Unusual bleeding (stool, nose, etc)
___ Bad breath
___ Poor appetite
___ Increased appetite
___ Crave sweets
___ Poor digestion
___ Nausea / vomiting
___ Bloating / gas
___ Hemorrhoids
___ Constipation
___ Loose stool
___ Alternate constipation / loose
___ Abdominal pain
___ Intestinal pain / cramping
___ Heartburn
___ Pensive / over-thinking
___ Overweight
___ Foggy mind
___ Yeast infection
___ Aversion to cold
___ Cold nose
___ Increased thirst
___ Prefer warm / cold drinks
___ Sweat easily

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)?

What is your occupation? Do you enjoy your work? How many hours per week do you work? Is it stressful? What are your duties?

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 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? Do you 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.)?

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Date last menses began /

Is your menstrual cycle: Regular___Irregular _____

How old were you when you had your first menstruation?	How many days do you bleed in total? /
	Menstrual cycle length (i.e. 26-30 days) /

Describe your flow: Heavy____Light_____Average__ **Consistency of blood**: Watery_____ Thick_ Average____

Does your blood contain clots? Yes____ No____ …and... **At which point during the cycle?** Start____ Mid____ End_

Describe the colour of your blood: (red, dark red, brown, purple, brownish red, bright red, pink, etc)

Do you experience menstrual pain? Yes___No ____	Before menses ___ During_____(please specify which days) After ___
What relieves the pain?	Stabbing ___ Cramping ___ Dull ___ Heavy ___ On/off ___

Do you experience pre-menstrual symptoms (PMS)? Please check all that apply.

Breast tenderness____ Cramps____ Acne____ Change in bowel____ Bloating____ Headaches____ Nausea____ Moodiness____
Fatigue_ Night sweats____ Sleep disturbances ___

Please list any other pre-menstrual symptoms

Do you ovulate on your own? Yes ___ No ___ What Day? _____	Do you chart your cycle? (circle) BBT / Ovulation sticks / Saliva
Do you experience pain around ovulation? Yes____ No ___	Do your breasts get tender around ovulation? Yes____ No ___
Do you notice stretchy clear egg white slippery cervical mucus around ovulation? Yes____ No ___	

How many times have you been pregnant?_____How many times have you given birth? _____
Ages of children_____Sex of children_____Given names _____
Have you had any miscarriages? Yes No ___
If yes, how many, at how many weeks pregnant, and in what year(s)?
_____
_
How many times have you had a D&C preformed? _____
How many abortions have you had?_____ In what year(s)?_____
Were there any problems that occurred during these pregnancies? _____

Have you ever been diagnosed with:

STD?_____.	Yes	No__
Pelvic inflammatory disease? ____	Yes	No
Uterine fibroids?_____..	Yes	No
Polyps?_____.	Yes	No
Pelvic adhesions? _____	Yes	No
Prolapsed uterus? _____	Yes	No
Unique shape of uterus?	Yes	No
Endometriosis?_____	Yes	No__
PCOS (polycystic ovarian syndrome)?_____..	Yes__	No__

Date of last pap smear:_____/_____/_____(dd/mm/yyyy)
Have you ever had an abnormal pap smear? Yes_ No____
Have you ever had a cervical biopsy or operation? Yes____ No____
Do you get yeast infections regularly? Yes____ No ___
Do you get bladder infections regularly? Yes____ No ___
If answered yes, list STDs:_____

Do you experience vaginal discharge? Yes____ No ___
If yes, what colour?
White____ Yellow____ Green____ Pinkish ___ Red ___
If yes, what consistency?
Watery / thin____ Thick____ Sticky ___
If yes, does it have foul odour? Yes____ No ___

Have you taken oral contraceptives? Yes____ No ___
If yes, for how long? _____
When did you stop? _____
Have you ever had an IUD? Yes____ No ___
Have you ever taken Depo-Provera? Yes____ No ___

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Have you had any hormone testing done? (e.g., Day 3, Day 21)

FSH_____...	___ Low	___ Normal	___ High
Estrogen (E2)_____...	___ Low	___ Normal	___ High
Progesterone_____._____...	___ Low	___ Normal	___ High
Prolactin_____....	___ Low	___ Normal	___ High
Thyroid (TSH)_____...	___ Low	___ Normal	___ High
Testosterone_____.	___ Low	___ Normal	___ High
Other: _____	___ Low	___ Normal	___ High

Do you currently have a partner? Yes No
If yes, what is your partner's name?_____ Age? _____
Are you married or living together?_____ For how long? _____
Is your partner supportive of your wishes to conceive?_____

How long have you been trying to conceive?_____

Do you have a family history of infertility (mother, father, grandparents, aunt, uncle, siblings)?_____
If yes, which family members?_____ Diagnosis?_____

Have you had a Western medical diagnosis relating for fertility? Yes No
If yes, what was the diagnosis?_____ Who made the diagnosis?_____

Has your partner (if applicable) had a Western medical diagnosis relating to fertility? Yes No
If yes, what was the diagnosis?_____ Who made the diagnosis?_____

Have you taken medication to help you ovulate? Yes No
If yes, what kind? _____ For how many cycles? _____

Have you had your uterine/fallopian tubes evaluated medically (HSG)? Yes No
What were the results?_____

Have you had any tubal operations? Yes No

Have you ever undergone assisted reproductive treatments? (IUI, IVF, ICSI superovulation, etc) Yes No

Month/Year	Type of treatment	Clinic	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What was your medical response to the fertility treatments?____Poor ___Average ___Good

Are you using donor sperm? Yes No
If yes, why? (no partner, female partner, male partner has semen issues, etc.)_____

Are you using donor eggs or embryos? Yes No

How is your sexual desire (mental interest)?.....	___ Low	___ Normal	___ High
How is your sexual arousal (physical/orgasm)?.....	___ Low	___ Normal	___ High!
Do you use vaginal lubricants?.....	__ Yes	__ No	
Have you been exposed to or received chemotherapy or radiation? __	__ Yes	__ No	
Do you have excessive facial or body hair?_____..	__ Yes	__ No	
Do you have excessively oily skin?_____.	__ Yes	__ No	

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On your journey toward parenthood, what expectations do you have of DeJongh Acupuncture Clinic? Please list the wellness goals you wish to obtain here:

Please consider letting us know what you need most from us during our time together (check as many as you wish):

____ **Perspective** (provide a fresh or different way of looking at a situation)

____ **Validation** (provide encouragement and acknowledgement)

____ **Message** (share fitting knowledge, opinions, or wisdom)

____ **Energy** (provide positive energy and support)

____ **Advice** (provide recommendations and suggestions)

____ **Feedback** (offer observations, insight, ideas, and opinions)

____ **Solutions** (share solutions to problems or issues)

____ **Plan** (co-develop a plan of action with you)

____ **Structure** (provide support and a check-in structure for you)

____ **Challenge** (provide a challenge to you to stretch or make a change)

____ **Tough love** (when necessary, have the conversations you may least want to have)

____ **Resource** (suggest/refer you to experts, books, tools, assessments)

____ **Caring** (provide listening, patience, safety, and love)

____ **Removed** (you may just want to come and relax, nothing more)

If there is anything else you would like us to know about you in order to make your experience here better, please share it here:

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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 profesional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimatley 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

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Patient Information Release Request Form

I,_____(please print name) understand that as part of the DeJongh Acupuncture Clinic effort to provide me with the highest standard of integrated care, they mayconsult 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) #:_____

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.

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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

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