

Welcome to Nurture Acupuncture

1520 The Alameda #130, San Jose, CA 95126

408.287.1390

100 Park Pl #200, San Ramon, CA 94583

925.395.7823

89 Davis Rd #280, Orinda, CA 94563

925.395.7823

Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. Nurture Acupuncture considers this information privileged physician/patient communication and will hold it in confidence.

Patient Information

NAME (First, Middle, Last)			DATE	
AGE	DATE OF BIRTH	SEX _ Male _ Female	MARITAL STATUS _ Single _ Married _ Separated _ Divorced _ Widowed	
HOME ADDRESS		CITY	STATE	ZIP
PHONE – HOME		CELL	EMAIL ADDRESS	
EMPLOYED BY				
EMPLOYERS ADDRESS		CITY	STATE	
OCCUPATION		WORK PHONE		
SPOUSE'S NAME				
CONTACT IN CASE OF AN EMERGENCY		RELATIONSHIP	PHONE	
MEDICAL INSURANCE CARRIER		POLICY NUMBER		
HOW DID YOU HEAR ABOUT OUR CLINIC?				
NAME OF YOUR OB-GYN DOCTOR		NAME OF YOUR FERTILITY OR REPRODUCTIVE CLINIC		

NAME (LAST, FIRST, MIDDLE)

DATE

Medical History

MAJOR COMPLAINT/HEALTH PROBLEM YOU WOULD LIKE US TO TREAT:

HOW DID THIS CONDITION DEVELOP?

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC.)

HOW LONG HAS THIS CONDITION PERSISTED?

IS THERE ANYTHING THAT MAKES IT BETTER OR WORSE?

IF YOU HAVE PAIN—IS IT SHARP OR SHOOTING, PINS AND NEEDLES, OR DULL? CHRONIC OR ACUTE?

NAME (LAST, FIRST, MIDDLE)

DATE

LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO:

Four horizontal lines for listing allergics.

LIST ANY MEDICATIONS/HERBS/DRUGS THAT YOU ARE CURRENTLY TAKING:

Four horizontal lines for listing medications.

LIST ANY MAJOR SURGERIES YOU HAVE HAD:

Two horizontal lines for listing surgeries.

Do you have a history of any of the following conditions?

Table with 6 columns: Condition, Yes, No, Condition, Yes, No. Lists various medical conditions for history taking.

NAME (LAST, FIRST, MIDDLE)

DATE

Health History

Please check any symptoms you currently have or have had in the past 6 months:

General

Chills
Low energy
Dizziness
Allergies
Fatigue
Fever
Excess thirst
Insomnia
Nervousness
Numbness
Sweat spontaneously
Night sweating
Lack of sweating
Weight loss
Weight gain
Aversion to heat
Aversion to cold

Head & Neck

Blurred vision
Heaviness in the head
Headache
Phlegm in throat
Cataract
Double vision
Earache
Ear discharge
Eye pain/strain
Corrected vision
Nasal obstruction
Nasal discharge
Loss of sense of smell
Hearing loss
Hoarseness
Nosebleeds
Recurrent sore throat
Red/inflamed eye
Ringing in ears
Sinus problems
Sores on lips
Sores on tongue
Taste change
Teeth problems
Vision – see halos

Respiratory

Asthma
Hay fever
Persistent cough
Coughing blood
Shortness of breath
Recurrent bronchitis
Phlegm production

Difficulty inhaling
Difficulty exhaling

Cardiovascular

Chest pain
High blood pressure
Low blood pressure
Irregular heart beat
Poor circulation
Swelling of ankles
Varicose veins
Hypochondriac pain
Distention in chest or hypochondrium

Gastrointestinal

Abdominal pain
Bloating
Belching
Gas
Constipation
Diarrhea/loose stools
Bloody stools
Black stools
Difficulty swallowing
Poor appetite
Heartburn/reflux
Hemorrhoids
Indigestion
Poor appetite
Stomachache
Nausea
Vomiting
Vomiting blood

Diet/Lifestyle

Vegetarian
Healthy diet
Eat much fried foods
Eat much meat
Smoke cigarettes
Drink alcohol
Drink coffee
Use drugs
Eat a lot of sweets
Take melatonin
Take steroids
Exercise regularly
Exercise excessively

Weight

Underweight
Normal for height
Overweight

Very overweight

Genitourinary

Dilute urine
Dark urine
Blood in urine
Cloudy urine
Burning urination
Scanty urine
Profuse urine
Frequent urination
Poor bladder control
Urgency to urinate

Musculoskeletal

Pain, weakness, numbness:
Arms
Feet
Hands
Joints
Legs
Hips
Neck
Shoulders
Pain all over
Cold limbs
Knee problems
Low back pain
All over weakness
Lack of strength
Broken bones

Skin

Thick skin
Thin skin
Broken blood vessels
Blood not clotting
Bruise easily
Discoloration
Dark circles around eyes
Bags under eyes
Lumps in groin
Lumps underarm
Dry skin
Acne
Brittle nails
Premature gray hair
Dry, brittle hair
Hair falling out

Neurologic

Fainting

Convulsions
Handwriting change
Paralysis
Stroke
Seizures
Tremor
Recent clumsiness
Drowsiness
Vertigo

Emotional

Insomnia
Irritability
Often feel angry
Troubling dreams
Cry uncontrollably
Feel sad a lot
Forgetful
Mind not clear
Anxiety
Much fear
Unrestrained joy
Terrors
Difficulty expressing emotions

Men Only

Genital pain
Impotence
Genital sores
Lump in testicles
Penis discharge
Nocturnal emission
Low sexual energy

Women Only

Abnormal pap smear
Bleed between periods
Irregular periods
Heavy periods
<25 day cycle
>35 day cycle
Endometriosis
Painful periods
Premenstrual tension
Breast lumps
Contraceptives
Sores on genitalia
Low sexual energy
Vaginal discharges
Menopausal
Uterine prolapse
Facial hair
Loss of head hair
May be pregnant

CONFIDENTIAL

NAME (LAST, FIRST, MIDDLE)

DATE

Age at which menses began _____

Date of last menstrual period _____

Are your periods painful? Yes No Somewhat How many days does the pain last?

Are your menstrual cycles spaced irregularly? Yes No

How many days are there from one period to the next? _____

How many days do you normally bleed? _____

How heavy is the bleeding? Light Normal Heavy

What color is the blood? Light red Red Dark red Purple Brown Black

Is there clotting? Yes No Size _____ Color _____

Do you bleed or spot between periods? Yes No

Do your bowel movements become loose at the beginning of you period or just prior to? Yes No

Do you have premenstrual tension? Yes No

Do your breasts become tender premenstrually? Yes No

Do you get premenstrual low back pain? Yes No

Does your face break out before or during your period? Yes No

Number Years

How many pregnancies have you had? _____

How many children do you have? _____

How many abortions have you had? _____

How many miscarriages have you had? _____

How many times has a D&C been performed? _____

Date of last Pap smear _____

Have you ever had an abnormal pap smear? Yes No

Have you ever had a cervical biopsy, operation, cauterization or conization? Yes No

CONFIDENTIAL

NAME (LAST, FIRST, MIDDLE)

DATE

Did you breastfeed? If so, how long? _____, If no, why? _____
How long after giving birth did it take for your menstrual cycle to return? _____

Have you ever had pelvic inflammatory disease? __ Yes __ No
Were you treated for it? __ Yes __ No
How _____

Do you get yeast infections regularly? __ Yes __ No How do you treat them?

Do you have chronic vaginal discharge? __ Yes __ No

Do you have any sores on your genitalia? __ Yes __ No

Have you ever been diagnosed with uterine fibroids or polyps? __ Yes __ No

Have you ever been diagnosed with endometriosis? __ Yes __ No

Have you ever been diagnosed with pelvic adhesions? __ Yes __ No

Have you been diagnosed with any pelvic abnormalities? __ Yes __ No

Have you taken any medications for gynecological conditions other than contraceptives? __ Yes
__ No

Medication	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since they began? __ Yes __ No
How? _____

Do you ovulate on your own? __ Yes __ No
On what day of your cycle? _____

Have you taken medication to help you ovulate? __ Yes __ No
When _____ How long? _____

CONFIDENTIAL

NAME (LAST, FIRST, MIDDLE)

DATE

Do you get stretchy cervical mucus around ovulation? Yes No

Do your breasts get tender at/during ovulation? Yes No

Do you use a BBT graph to chart your temperature rise and ovulation? Yes No

Have you had fertility treatments? Yes No

If yes, when and where? _____

By whom? _____

What types? _____

Do you know what your FSH level is on Day 3? Yes No

Have your fallopian tubes been evaluated medically? Yes No

What were the results? _____

Have you had any tubal operations? Yes No

Have you had any hormone laboratory tests performed? Yes No

What were the results? _____

Has your partner or spouse had a fertility workup? Yes No

What were the results? _____

Is your partner supportive of your wish to conceive? Yes No

How is your sexual energy? Low Normal High

Do you douche regularly? Yes No

With what? _____

Do you use vaginal lubricants? Yes No

Are you more than 20% over your ideal body weight? Yes No

Are you more than 20% below your ideal body weight? Yes No

Do you have a stressful occupation? Yes No

Do you exercise regularly? Yes No

Do you have excessive facial hair? Yes No

Do you have excessively oily skin? Yes No

Have you experienced excessive loss of head hair? Yes No

Have you noticed discharge from your nipples? Yes No

NAME (LAST, FIRST, MIDDLE)

DATE

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? Yes No

Have you been exposed to any known environmental toxins or hormones? Yes No

Are you presently taking steroids? Yes No

Any irregular lab results for the thyroid? Yes No

Do you have natural killer cells? Yes No

Have you done LIT or IVIG? Yes No When? _____

Have you taken oral contraceptives? Yes No
When _____ How long? _____

Have you ever had an IUD? Yes No
When _____ How long? _____

Have you ever taken Depo Provera? Yes No
When _____ How long? _____

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? Yes No
What was it? _____

Are you planning to do?

IUI _____ IVF _____ OTHER _____

Estimated date of procedure _____

What drugs/medications will you be taking in preparation for this procedure and when do you start?

NAME (LAST, FIRST, MIDDLE)

DATE

Male Fertility History

Have you ever been diagnosed with a varicocele? Yes No

Have you had any urologic surgeries? Yes No

Have you experienced difficulty maintaining an erection?..... Yes No

Have you experienced difficulty ejaculating?..... Yes No

Have you had exposure to any known environmental toxins or hormones? Yes No

Have you experienced any penile discharge? Yes No

Do you regularly experience nocturnal emission?..... Yes No

Have you had a fertility workup?..... Yes No

If yes, what was your sperm count? __ Below normal __ Normal Number _____

What was the sperm motility? __ Below normal __ Normal Number _____

What was the sperm morphology? __ Abnormal __ Normal Number _____

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CONSENT FOR ACUPUNCTURE TREATMENT

I hereby request and consent to acupuncture treatments and other procedures within the scope of the practice of acupuncture on me by the acupuncturist named below.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxa, massage, cupping, electrical stimulation, Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. I will immediately notify my acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including bruising and/or numbness or tingling near the needling sites that may last a few days.

There have been rare instances reported in which a patient fainted, developed a scar or infections, experienced a spontaneous abortion, or sustained a pneumothorax (air in the chest cavity that could cause a collapsed lung). The herbs and nutritional supplements that have been recommended are considered safe in the practice of Chinese medicine. Some herbs may have undesirable effects in larger doses than we recommend. Some possible side effects of taking herbs are nausea, gas, stomachache, diarrhea or rashes. I will notify my acupuncturist if I am pregnant since some herbs can be harmful.

I do not expect my acupuncturist to be able to anticipate and explain all possible risks and complications of treatments, and I wish to rely on my acupuncturist to exercise good judgment during the course of treatment. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

Patient Signature: _____

Date: _____

Acupuncturist Signature: _____

Date: _____

Nurture Acupuncture financial policy

I understand that health insurance policies are an arrangement between an insurance carrier and myself. I assume full responsibility for verification of benefits including which services are covered under my policy, portion of fees covered, and annual maximum of coverage. I am responsible for making sure that I am treated by the in network provider if I only have in network benefits. Furthermore, I understand that NurtureAcupuncture will prepare any necessary reports and claim forms to assist me in collecting reimbursement from my insurance company and that I will be responsible for any funds not covered by my insurance . Full payment will be collected until an insurance guarantee is received. Any amount paid in excess to the provider will be reimbursed to the patient by check upon receipt. I clearly understand that all services rendered are charged directly to me and that I am personally responsible for payment in full at the time of service. Nurture Acupuncture reserves the right to bill insurance at a "reasonable and customary" fee structure. If your insurance does not cover the frist visit fee , then I understand that I will have to cover this fee. Nurture Acupuncture is in the network with the following insurance carriers: **United Healthcare, Cigna, UMR, Sutter Select, and Blue Shield.**

Your appointment time is reserved specifically for you. Therefore, Nurture Acupuncture requests at least **24 hours notice for any cancellation** or rescheduling of appointment times. Repeat missed appointments or short notice cancellations may result in a missed appointment fee of \$50.00. Exceptions to this policy may include cancellations due to illness, family or personal emergency, and last minute changes in scheduling of procedures with your medical doctor. Please notify Nurture Acupuncture as soon as possible if you are unable to keep your appointment for any of these reasons.

Nurture Acupuncture fee schedule:

Initial Visit: \$140.00-\$250 (treatment and diagnosis)
Acupuncture/ Reproductive Organ Massage: \$85.00-\$135
Pre/Post Embryo Transfer on day of Transfer New Patient: \$250
Cash Price per visit \$75.00
Cash Prepay package-11 treatments \$750.00
Visa or Check Prepay package-11 treatments \$850.00

***Prepay packages are non-refundable and may be transferred to another patient.
Prepay packages are only available for patients that have no active insurance.***

Insurance will only be billed on the Primary Insurance. Patient to bill their on Secondary Insurance.

Herb and supplement prices are variable according to amount and type of medication prescribed

Please sign and date below stating that you have received and understand the above policies

_____ Date: _____

