

# Welcome to Nurture Acupuncture

1520 The Alameda #130 San Jose CA 95126 408.287.1390  
100 Park Place #200 San Ramon CA 94583 925.395.7823  
1098 Foster City Blvd 205 Foster City CA 94404 408.287.1390

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		

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NAME (LAST, FIRST, MIDDLE)

DATE

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## Medical History

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

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HOW DID THIS CONDITION DEVELOP?

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SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC.)

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HOW LONG HAS THIS CONDITION PERSISTED?

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IS THERE ANYTHING THAT MAKES IT BETTER OR WORSE?

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

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**CONFIDENTIAL**

NAME (LAST, FIRST, MIDDLE)

DATE

LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO:

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

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LIST ANY MAJOR SURGERIES YOU HAVE HAD:

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

AIDS	Yes	No	High Blood Pressure	Yes	No
Anxiety Attacks	Yes	No	Intestinal Bleeding	Yes	No
Asthma	Yes	No	Kidney Infection	Yes	No
Autoimmune Disease	Yes	No	Kidney Stones	Yes	No
Birth Defects	Yes	No	Lupus Erythematosus	Yes	No
Bladder Infections	Yes	No	Migraine	Yes	No
Blood Disorders	Yes	No	Neurologic Disorders	Yes	No
Breast Tumors or Cancer	Yes	No	Other Forms of Arthritis	Yes	No
Bronchitis	Yes	No	Other Heart Conditions	Yes	No
Cancer	Yes	No	Other Kidney Problems	Yes	No
Cirrhosis	Yes	No	Other Lung Problems	Yes	No
Connective Tissue Disorders	Yes	No	Panic Attacks	Yes	No
Diabetes	Yes	No	Paralysis	Yes	No
Epilepsy	Yes	No	Pneumonia	Yes	No
Gallstones	Yes	No	Prolonged Dizziness	Yes	No
Gastric/Duodenal Ulcers	Yes	No	Rheumatic Fever	Yes	No
German Measles (Rubella)	Yes	No	Rheumatoid Arthritis	Yes	No
Glasses/Contact lenses	Yes	No	Seizures	Yes	No
Heart Attack	Yes	No	Thyroid Problems	Yes	No
Heart Disease	Yes	No	Tuberculosis	Yes	No
Heart Murmur	Yes	No	Varicose Veins	Yes	No
Hepatitis	Yes	No			

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NAME (LAST, FIRST, MIDDLE)

DATE

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

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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

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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? \_\_\_\_\_



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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? \_\_\_\_\_

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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

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NAME (LAST, FIRST, MIDDLE)

DATE

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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?

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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 first 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.** (this is subject to change)

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:

1st 30 minute Consultation	No Charge
Additional Consultations	\$50
1st Initial Treatment with Diagnosis	\$140 to \$250
Acupuncture/ Reproductive Organ Massage	\$95 to \$150
Pre/Post Embryo Transfer on day of Transfer New Patient	\$250
Cash Price per visit	\$85
Cash Prepay Package - 11 Treatments	\$850
· Visa or Check Prepay Package - 11 Treatments	\$950

*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: \_\_\_\_\_