



Fertile Ground Wellness Center
1091 S. Gaylord St.
Denver, CO 80209

Office: (303)248-3481
Fax: (720) 836-4174
fertilegroundwellnesscenter@gmail.com

Female Fertility Intake Form

Name _____ Date of birth ____/____/____ Age _____

Street Address _____

City _____ State _____ Zip _____

Phone _____ Alternate Phone _____

Email address _____

Yes, I would like to be added to the Fertile Ground email list

Employer _____ Phone _____

Occupation _____

Marital Status _____ Number of Children _____

Personal Physician _____ Phone _____

Emergency Contact _____ Phone _____

Who can we thank for referring you to our office? _____

Clinic Policy

Your appointment time has been specifically reserved for you. If you need to cancel an appointment, we ask that you give 24 hours notice. If less than 24 hours notice is given for a cancelled appointment or an appointment is missed, we reserve the right to bill you for the full amount of the appointment.

Payment for services will be due at the time of the visit. Cash, checks, and credit cards are acceptable forms of payment. Credit cards are processed through Therapy Partner. Upon your request, an invoice with procedure codes and diagnosis codes can be printed for you to submit to your insurance company. However, Fertile Ground cannot be responsible for the insurance company's failure to reimburse.

Signature

Please indicate your understanding and acceptance of these policies by signing below:

Signed _____ Date _____

HIPPA Form

Please check and initial the following to indicate you have read and understand the information in these forms and accept the policies therein: *Initials*

HIPPA Form & Protecting Your Health Information _____

Acupuncture Informed Consent

I hereby request and consent to the performance of acupuncture and/or Chinese herbal treatments and other procedures within the scope of acupuncture on me (or the patient named below, for whom I am legally responsible) by the acupuncturist, named below and or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as a back-up for the acupuncturist named below.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Public Health and Environment, including the use of single-use, sterile needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are used in this clinic. There are some risks to treatment including but not limited to some bruising of the skin and/or slight bleeding.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Licensure Office, 1560 Broadway, Suite 1340, Denver, CO 80202. Telephone (303) 894-7851.

I have had an opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture. I understand that the results are not guaranteed.

Patient Rights

- The patient is entitled to receive information about methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

I have read, or have had read to me, the above consent and have had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend for 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: _____

Practitioner Signature: _____ Date: _____

Cecily Yousaf, MSOM, L.Ac.

Licensed Acupuncturist and Owner of Fertile Ground

Acupuncture Fee Schedule

Adults	Couples	Lactation	Pediatrics
New patient: \$120.00	\$120.00	New patient: \$70.00	Infant-3 years: \$60.00
Return visit: \$70.00		Return visit: \$60.00	

The first office visit is 1-1.5 hours in length, return office visits are generally 1 hour in length.

Signature

Please indicate your understanding and acceptance of the acupuncture fee schedule:

Signed _____ Date _____

Acupuncture Disclosure Form

Please check and initial the following to indicate you have read and understand the information in the Acupuncture Disclosure Form and accept the policies therein: _____ *Initials*

Acupuncture Disclosure Form _____

General Information

	Yes	No
Have you ever had acupuncture before?	<input type="checkbox"/>	<input type="checkbox"/>
Are you now or could you be pregnant? Date of conception_____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of miscarriage?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker, heart arrhythmia, or other heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had blood-clotting problems or problems with bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
Are you on blood thinning medications?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take aspirin regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
HIV?	<input type="checkbox"/>	<input type="checkbox"/>
AIDS?	<input type="checkbox"/>	<input type="checkbox"/>
TB?	<input type="checkbox"/>	<input type="checkbox"/>
If so, when?_____		

Prescription Medications

Please list any non-fertility prescription medications you are currently taking and what they are for:

Surgical History

Please list all surgeries and approximate age:

Hospitalizations

Allergies

Specific allergen and reaction:

Major Accidents/Injuries

Please list any major accidents (include head injuries, fractures, deep cuts, serious sprains, etc.) Indicate date or age:

Family Medical History

Please indicate any illness or disorders that have occurred in your immediate family (include parents, siblings, and grandparents)

- Diabetes Cancer High Blood Pressure Heart Disease
- Stroke Other_____

Sleep

Please describe your sleep

Hours per night _____

Do you wake most nights? _____ Do you wake at the same time most nights? _____

Do you have trouble falling asleep? Yes No

Emotional/Cognitive

Do you experience an emotion/pattern often or excessively

If so, which emotions/patterns?

- Anger Fear Worry Sadness/Grief
- Joy Depression Cry Easily Frustration
- Mood-swings Poor memory Easily irritable Foggy thinking
- Explosive outbursts
- Difficulty making decisions
- Obsessive/repetitive thinking
- Tendency to hold things in

If you experience mood-swings, are they related to eating/not-eating? _____

If you are female and have mood-swings, are they related to your menstrual cycle? _____

Stress

List major stressors in your life

Exercise

Do you exercise regularly? Yes No
Please describe type & frequency/week

- Yes No Are you presently taking steroids?
- Yes No 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?

Complimentary Health Care

List any previous complimentary health care that you have participated in:

	<i>Last visit date</i>	<i>Reason for care</i>	<i>Treatment ongoing</i>
<input type="checkbox"/> Acupuncture	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Massage Therapy	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Chiropractic Care	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Naturopathic Care	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Hypnotherapy	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other	_____	_____	<input type="checkbox"/>

Fertility History

How long have you been trying to conceive? _____

Is there a history of difficulty conceiving or pregnancy loss in your family? _____

<i>Fertility History</i>	<i>Dates</i>
<input type="checkbox"/> Pregnancies	_____
<input type="checkbox"/> Births	_____
<input type="checkbox"/> Miscarriages	_____
<input type="checkbox"/> Terminations	_____
<input type="checkbox"/> Ectopics	_____
<input type="checkbox"/> D&C	_____
<input type="checkbox"/> Abnormal Pap Smear	_____

Fertility Treatments

Have you had fertility treatments? Yes No

If yes, are you being treated by:

- RE & I Clinic/Fertility Specialist: RMFC CCRM FCC Conceptions
- CU Albrecht Women's Care

Which doctor are you seeing at this clinic? _____

Other OBGYN doctor _____

Start Date: _____ Month/Year

Have you had a diagnosis related to fertility? Yes No

Western Diagnosis _____

<i>Your Diagnostics</i>	<i>Date</i>	<i>Your Diagnostics</i>	<i>Date</i>
<input type="checkbox"/> Elevated FSH	_____	<input type="checkbox"/> Low Progesterone Level	_____
<input type="checkbox"/> Uterine Fibroids/Polyps	_____	<input type="checkbox"/> PID	_____
<input type="checkbox"/> Endometriosis/Adhesions	_____	<input type="checkbox"/> Chlamydia	_____
<input type="checkbox"/> PCOS	_____	<input type="checkbox"/> Herpes	_____
<input type="checkbox"/> POF	_____	<input type="checkbox"/> Other STD's:	_____
<input type="checkbox"/> Antisperm antibodies	_____	<input type="checkbox"/> Other diagnostics:	_____

Fertility Medications

Have you taken medication to help you ovulate? Yes No

When? _____ How long? _____

If you have been diagnosed with PCOS, are you taking

Glucophage How long? _____ Fortamet How long? _____
 Are you taking extra B-Complex vitamins? Yes No

<i>Procedures performed</i>	<i>Dates</i>	<i>Results</i>
<input type="checkbox"/> Laparoscopy	_____	_____
<input type="checkbox"/> HSG (Hysterosalpingogram)	_____	_____
<input type="checkbox"/> PI (Pulsatility Index)	_____	_____

Have you had any tubal operations? Yes No

<i>Lab Tests</i>	<i>Dates</i>	<i>Results</i>
<input type="checkbox"/> FSH Level Day 3	_____	_____
<input type="checkbox"/> HCG	_____	_____
<input type="checkbox"/> Prolactin	_____	_____
<input type="checkbox"/> TSH	_____	_____
<input type="checkbox"/> T3	_____	_____
<input type="checkbox"/> T4	_____	_____
<input type="checkbox"/> Free T4	_____	_____
<input type="checkbox"/> OAR	_____	_____
<input type="checkbox"/> Others:	_____	_____

Fertility Treatments (including cancelled cycles):

<i>Date</i>	<i>Natural, IUI, IVF, other</i>	<i>Medication used</i>	<i># of mature eggs /follicles</i>	<i>Pregnancy Yes/No</i>	<i>If miscarried, what week?</i>

Future ART Plans

Date

- IUI w/ injectables _____
- IUI w/ oral meds _____
- Clomid _____
- IVF _____
- PGD _____
- Other: _____

Reproductive Health

When did your last period start? _____ What day of your cycle are you on today? _____

At what age did menses begin? _____ Do you have regular pap tests? Yes No

Are you currently charting your menstrual cycles (BBT charting)? Yes No

Do you receive or give yourself regular breast exams? Yes No

Do you douche regularly? Yes No

Do you use vaginal lubricants? Yes No

Do you use tampons? Yes No

How is your sexual energy?

- High
- Normal
- Low
- None

Are you experiencing any sexual problems? Yes No

If yes, please explain: _____

Please give the following information about your periods.

- | | Yes | No |
|--|--------------------------|--------------------------|
| Is your period regular? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your periods painful? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you bleed excessively? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you bleed too little/scanty? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you discharge clots? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have headaches before your period? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get headaches after you bleed? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you experience tightness in your chest? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you experience low backache? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you tend to sigh a lot? | <input type="checkbox"/> | <input type="checkbox"/> |

How many days are there between one period and the next? _____

How many days do your periods last? _____

Describe menstrual flow:

- Heavy Moderate Light None

Color of menstrual flow:

- Dark Bright red Slightly reddish Brown (at beginning/end of period)

Clotting (mark as appropriate):

- Bright in color Brown/grainy Stringy Dark in color

- Size of clots: Dime Nickel Larger

Cramping (mark as appropriate)

- Where are your cramps? Low back Groin area Down legs
When do you feel them? Before period During period During ovulation
Severity of cramps Mild Moderate Severe

Do you use pain medication? _____ What kind of medication? _____

PMS

	10 days before	1 week before	2-3 days before
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loose stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial break-outs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating/water retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have a history of:

- Amenorrhea Menstrual cramps Ovarian cysts Failure to ovulate
 Ectopic pregnancy Pelvic Inflammatory Disease Endometriosis Painful intercourse
 Uterine fibroids Irregular periods Chronic vaginal or yeast infections
 Vaginal discharge Bleeding between periods

Contraception History

Method	Length of time used	How long ago?
Pills	_____	_____
Patch (Ortho Evra)	_____	_____
Diaphragm	_____	_____
Shot (Depo-Provera)	_____	_____
Condoms	_____	_____
IUD	_____	_____
Vaginal ring (NuvaRing)	_____	_____
Rhythm method	_____	_____
Fertility Awareness Method	_____	_____
Other:	_____	_____

Nutrition/Diet Information

Please describe your appetite

- Strong Normal Poor

Do you hunger quickly? Yes No

Please describe your diet (low fat, low-carb, vegetarian, etc.)

Please list what you ate yesterday

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How much water do you drink per day? _____

Other fluids _____

Please describe your thirst

- Strong Normal Poor

If you eat any of the following, please check and list how much per week

- | | |
|---|--|
| <input type="checkbox"/> Candy _____ | <input type="checkbox"/> Cheese _____ |
| <input type="checkbox"/> Cookies/Bake goods _____ | <input type="checkbox"/> Fast food _____ |
| <input type="checkbox"/> Chocolate _____ | <input type="checkbox"/> Protein _____ |
| <input type="checkbox"/> White flour bread _____ | <input type="checkbox"/> Vegetables-dark green _____ |
| <input type="checkbox"/> Soda-Regular/Diet _____ | <input type="checkbox"/> Fruit _____ |
| <input type="checkbox"/> Milk-skim/2%/whole _____ | <input type="checkbox"/> Alcohol _____ |
| <input type="checkbox"/> Caffeine _____ | |

Supplements/Vitamins

Are you taking any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Prenatal Vitamin (Brand: _____) | <input type="checkbox"/> Royal Jelly/Propolis |
| <input type="checkbox"/> Fish oil (Brand: _____) | <input type="checkbox"/> Additional Folic Acid |
| <input type="checkbox"/> Antioxidants | <input type="checkbox"/> Others: |

Partner Information

Partner's Name _____

Has your partner had a fertility workup? Yes No

Western Diagnosis of your partner _____

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

Does your partner experience any sexual dysfunction? Yes No