



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

Office: (303)248-3481  
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fertilegroundwellnesscenter@gmail.com

## General Health 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**

|                       |                |                       |                         |
|-----------------------|----------------|-----------------------|-------------------------|
| <i>Adults</i>         | <i>Couples</i> | <i>Lactation</i>      | <i>Pediatrics</i>       |
| 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?<br>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,<br>or other heart condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had blood-clotting problems or<br>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 prescription medications you are currently taking and what they are for:

**Vitamins/Supplements**

Please list any vitamins or other supplements you are taking:

**Surgical History**

Please list all surgeries and approximate age:

**Major Accidents/Injuries**

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

**Primary Complaint**

Please include: description of complaint, location, date and/or time of onset, cause (if known), frequency of problem, factors aggravating symptoms, factors alleviating symptoms, etc.

|   |                          |                          |
|---|--------------------------|--------------------------|
|   | YES                      | NO                       |
| Have you ever had this condition or one like it before? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been treated for this condition before?   | <input type="checkbox"/> | <input type="checkbox"/> |

When? \_\_\_\_\_ By whom? \_\_\_\_\_

Has your condition improved, stayed the same or gotten worse? \_\_\_\_\_

Is there pain associated with this condition?  YES  NO  
Please describe the pain (stabbing, burning, stitching, drawing, boring, dull ache, fixed, wandering, colicky, spasmodic, distending, etc.) \_\_\_\_\_

Is your pain affected by applying heat or cold? \_\_\_\_\_

Is the pain better with rest or activity? \_\_\_\_\_

Is the problem affected by climate, weather changes, etc.  YES  NO

If so, what type of weather aggravates it? \_\_\_\_\_

What are the possible emotional or stress factors related to the condition/problem?

Is there a time of day or night when the condition/problem is worse?

Are there any other symptoms that manifest with the Primary Complaint?

**Secondary Complaints:**

**General Condition**

Please check any of the following that *presently* apply to you:

**Energy Levels**

- Are you fatigued or do you fatigue easily
- Do you need to take naps
- Do you generally feel cold
- Do you have cold feet and/or hands
- Do you catch colds frequently
- Do you have energy slumps at certain times of day
- Do you wake up tired in the morning
- Do you feel energized after exercise
- Do you regularly have a low-grade fever
- Does your sweat have a strong odor
- Do you ever wake up sweating at night
- Do you perspire easily without exertion
- Do you feel tired after meals
- Do you have excess/nervous energy
- Does your energy pick up after you get up and move about in the morning

**Appetite and Digestion**

- Has your appetite changed lately
- Do you have a poor appetite
- Are you hungry all/most of the time
- Do you feel foggy or low if you miss a meal
- Do you have abdominal (intestinal) bloating
- Do you experience belching/hiccups
- Do you have heartburn
- Do you have gurgling sounds in your intestines
- Do you have a nervous stomach
- Do you have intestinal gas
- Do you experience a bitter taste
- Do you have acid regurgitation
- Do you crave particular foods
  - Sweet
  - Salty
  - Bitter
  - Sour
  - Hot or spicy
- Do you experience bad breath

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

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 _____           |  |

### Dryness

How much water do you drink each day? \_\_\_\_\_

Other fluids \_\_\_\_\_

Do you prefer your drinks:  cold  warm/hot  room temperature

Please describe your thirst

Strong  Normal  Poor

- |  |  |
|--|--|
| <input type="checkbox"/> Do you have dry eyes                  | <input type="checkbox"/> Do you have dry hair            |
| <input type="checkbox"/> Do you have a dry nose                | <input type="checkbox"/> Do you have dry skin            |
| <input type="checkbox"/> Do your mouth and lips tend to be dry | <input type="checkbox"/> Do you have frequent nosebleeds |

### Stools & Urine

Do you have or experience:

- |  |   |
|--|---|
| <input type="checkbox"/> Bowel movements less than 5x/week                             | <input type="checkbox"/> Wake at night to urinate |
| <input type="checkbox"/> Bowel movements more than 2x/day                              | <input type="checkbox"/> Dribbling urine          |
| <input type="checkbox"/> Blood or pus in your stools                                   | <input type="checkbox"/> An urgency to urinate    |
| <input type="checkbox"/> Stools unusually light/dark in color                          | <input type="checkbox"/> Urine with a strong odor |
| <input type="checkbox"/> Any undigested food in your stool                             | <input type="checkbox"/> Burning with urination   |
| <input type="checkbox"/> Constipation  | <input type="checkbox"/> Incontinence             |
| <input type="checkbox"/> Diarrhea  | <input type="checkbox"/> Cloudy urine             |
| <input type="checkbox"/> Alternating constipation and diarrhea                         | <input type="checkbox"/> Blood in your urine      |
| <input type="checkbox"/> Hemorrhoids   | <input type="checkbox"/> Abdominal pain/cramps    |
| <input type="checkbox"/> Excessive gas   |   |
| <input type="checkbox"/> A feeling of being unfinished after the stool is discharged   |   |
| <input type="checkbox"/> Abdominal discomfort that is relieved after passing the stool |   |

### Sleep

- |   |   |
|---|---|
| <input type="checkbox"/> Are you easily startled                                  | <input type="checkbox"/> Do you have restless/fitful sleep    |
| <input type="checkbox"/> Do you dream excessively                                 | <input type="checkbox"/> Do you have trouble getting to sleep |
| <input type="checkbox"/> Do you wake early and have trouble getting back to sleep |   |
| <input type="checkbox"/> Do you experience insomnia                               |   |
| <input type="checkbox"/> If so, do you wake at the same time most nights?         | What time? _____  |

### Emotional/Cognitive

- Do you experience an emotion/pattern often or excessively
- If so, which emotions/patterns?
- |  |                                      |   |   |
|--|--------------------------------------|---|---|
| <input type="checkbox"/> Anger                         | <input type="checkbox"/> Fear        | <input type="checkbox"/> Worry            | <input type="checkbox"/> Sadness/Grief  |
| <input type="checkbox"/> Joy                           | <input type="checkbox"/> Depression  | <input type="checkbox"/> Cry Easily       | <input type="checkbox"/> Frustration    |
| <input type="checkbox"/> Mood-swings                   | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Easily irritable | <input type="checkbox"/> Foggy thinking |
| <input type="checkbox"/> Explosive outbursts           |                                      |   |   |
| <input type="checkbox"/> Difficulty making decisions   |                                      |   |   |
| <input type="checkbox"/> Obsessive/repetitive thinking |                                      |   |   |
| <input type="checkbox"/> 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? \_\_\_\_\_

### Chronic Pain

- Do you suffer from chronic or occasional backache or neck-ache
  - Do you suffer from chronic or occasional joint pain
    - If so, which joints? \_\_\_\_\_
  - Do any muscles ache or cramp       Do you get muscle twitches or spasms
  - Is your pain worse with certain weather conditions
    - If so, what type of weather? \_\_\_\_\_
  - Do you get frequent headaches/migraines
    - If so, what is the location of the pain? (frontal, occipital, temporal, vertex, center of brain)  
\_\_\_\_\_
- Is the pain:     dull/achy     stabbing     burning     empty  
                   like a band wrapped around your head     pressure behind the eyeballs  
                   other \_\_\_\_\_

### General Health

Do you have or experience:

- |   |  |
|---|--|
| <input type="checkbox"/> Dizziness or vertigo                   | <input type="checkbox"/> Heart palpitations                |
| <input type="checkbox"/> Tinnitus (ear ringing)                 | <input type="checkbox"/> Irregular heartbeat               |
| <input type="checkbox"/> Any hearing loss                       | <input type="checkbox"/> Bruise easily                     |
| <input type="checkbox"/> Unusual hair loss or premature graying | <input type="checkbox"/> Shortness of breath               |
| <input type="checkbox"/> Tooth decay/looser teeth               | <input type="checkbox"/> Shallow breathing                 |
| <input type="checkbox"/> Gum problems/bleeding                  | <input type="checkbox"/> Blurred vision                    |
| <input type="checkbox"/> Aversion to cold                       | <input type="checkbox"/> Night blindness                   |
| <input type="checkbox"/> Tingling or numbness sensations        | <input type="checkbox"/> Chest pain/oppression             |
| <input type="checkbox"/> Color blindness                        | <input type="checkbox"/> Sweating less than normal         |
| <input type="checkbox"/> Sweating more than normal              | <input type="checkbox"/> Sweat that stains clothes yellow  |
| <input type="checkbox"/> Sweat with a particularly strong odor  | <input type="checkbox"/> Earaches/discharge from your ears |
| <br>  |  |
| <input type="checkbox"/> High stress level                      | <input type="checkbox"/> Mouth/tongue sores                |
| <input type="checkbox"/> Lump in your throat                    | <input type="checkbox"/> Sighing a lot                     |
| <input type="checkbox"/> Regular exercise                       | <input type="checkbox"/> Aversion to heat                  |
| <input type="checkbox"/> Grinding your teeth                    | <input type="checkbox"/> Aversion to wind                  |
| <input type="checkbox"/> Clenching your jaw                     | <input type="checkbox"/> Red face or eyes                  |
| <input type="checkbox"/> Jaw pain or TMJ                        | <input type="checkbox"/> Acne                              |
| <input type="checkbox"/> Tremors                                | <input type="checkbox"/> Skin rashes/itching               |
| <input type="checkbox"/> Flank or rib pain/discomfort           | <input type="checkbox"/> Slowly healing cuts               |
| <br>  |  |
| <input type="checkbox"/> Recent rapid weight gain/loss          | <input type="checkbox"/> Brittle nails/nails break easily  |
| <input type="checkbox"/> Frequent nausea                        | <input type="checkbox"/> Nails with ridges, spots or lines |
| <input type="checkbox"/> Preference for warm/cold foods         | <input type="checkbox"/> Eyes tearing or straining easily  |
| <input type="checkbox"/> Eyes sensitive to light                | <input type="checkbox"/> Frequent twitches in eye/eyes     |
| <input type="checkbox"/> Frequent colds/flu                     | <input type="checkbox"/> Pale color under eyelids          |

### Men Only

Do you have or experience:

- |   |   |
|---|---|
| <input type="checkbox"/> Reduced sexual drive           | <input type="checkbox"/> Impotence                            |
| <input type="checkbox"/> Premature ejaculation          | <input type="checkbox"/> Genital pain                         |
| <input type="checkbox"/> Ejaculations during your sleep | <input type="checkbox"/> Unusual discharge                    |
| <input type="checkbox"/> Prostate problems              | <input type="checkbox"/> Painful/burning urination            |
| <input type="checkbox"/> Dribbling urine                | <input type="checkbox"/> Uneven force in your stream of urine |

**Women Only**

YES NO

Do you have regular pap tests?

Do you receive or give yourself regular breast exams?

Do you have a history of:

- Amenorrhea
- Ectopic pregnancy
- Uterine fibroids
- Vaginal discharge
- Menstrual cramps
- Pelvic Inflammatory Disease
- Irregular periods
- Chronic vaginal or yeast infections
- Ovarian cysts
- Endometriosis
- Reduced sexual drive

**Birth Control History**

Birth control pills \_\_\_\_\_ Number of years \_\_\_\_\_

IUD \_\_\_\_\_ Number of years \_\_\_\_\_

Abortion(s) \_\_\_\_\_ Number \_\_\_\_\_

Following birth, abortion or miscarriage, were there any health problems? If so, please explain.

**Menstrual History**

Are you currently pregnant? \_\_\_\_\_ Number of children \_\_\_\_\_

Age of menarche \_\_\_\_\_ Have you had a hysterectomy? \_\_\_\_\_

Are you presently suffering from menopausal disorder? \_\_\_ hot flashes? \_\_\_ night sweats? \_\_\_

Please give the following information about your periods. If you no longer have periods, indicate what they were like before they stopped.

YES NO

Is your period regular?

Are your periods painful?

Do you bleed excessively?

Do you bleed too little/scanty?

Do you discharge clots?

Do you have headaches before your period?

Do you get headaches after you bleed?

Do you experience tightness in your chest?

Do you experience low backache?

Do you tend to sigh a lot?

How many days between your periods? \_\_\_\_\_ How many days do your periods last? \_\_\_\_\_

Is your menstrual blood bright red, pale red, dark red, or rusty colored? \_\_\_\_\_

Do you suffer from premenstrual syndrome (PMS)?  Yes  No

- Breast distension/swelling
- Emotional changes
- Pain/cramps relieved by bleeding
- Breast lumps
- Irritability
- Pain/cramps made worse by bleeding
- Water retention
- Breast tenderness

Other: \_\_\_\_\_

**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     Seizures     Asthma     Allergies     Substance Abuse  
 Other \_\_\_\_\_

**Disease History**

Please indicate if you have had any of the following:

|                         | <i>Past</i>              | <i>Present</i>           |                                | <i>Past</i>              | <i>Present</i>           |
|-------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|
| Allergies               | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina                  | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia                  | <input type="checkbox"/> | <input type="checkbox"/> | Heat Stroke                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis               | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma                  | <input type="checkbox"/> | <input type="checkbox"/> | Irritable Bowel Syndrome       | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Pressure Problems | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer                  | <input type="checkbox"/> | <input type="checkbox"/> | Mental Illness                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Candida                 | <input type="checkbox"/> | <input type="checkbox"/> | Mononucleosis                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic cough           | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems              | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold Sores              | <input type="checkbox"/> | <input type="checkbox"/> | Serious or prolonged fever     | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes                | <input type="checkbox"/> | <input type="checkbox"/> | Shingles                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating Disorders        | <input type="checkbox"/> | <input type="checkbox"/> | Sinus infections               | <input type="checkbox"/> | <input type="checkbox"/> |
| Edema                   | <input type="checkbox"/> | <input type="checkbox"/> | Skin problems                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy                | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Epstein-Barr Syndrome   | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease               | <input type="checkbox"/> | <input type="checkbox"/> |
| Food Allergies          | <input type="checkbox"/> | <input type="checkbox"/> | Varicose Veins                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Gallstones              | <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heartbeat/Arrhythmia | <input type="checkbox"/> | <input type="checkbox"/> |
| Genital Herpes          | <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol               | <input type="checkbox"/> | <input type="checkbox"/> |

Other: \_\_\_\_\_

**Drug History**

Please indicate past or present use of the following:

|                              | <i>Past</i>              | <i>Present</i>           | <i>Years usage</i> |
|------------------------------|--------------------------|--------------------------|--------------------|
| Anti-depressants             | <input type="checkbox"/> | <input type="checkbox"/> | _____              |
| Antibiotics                  | <input type="checkbox"/> | <input type="checkbox"/> | _____              |
| Estrogen/birth control pills | <input type="checkbox"/> | <input type="checkbox"/> | _____              |
| Pain medication              | <input type="checkbox"/> | <input type="checkbox"/> | _____              |
| Prednisone/other steroids    | <input type="checkbox"/> | <input type="checkbox"/> | _____              |
| Sleeping pills               | <input type="checkbox"/> | <input type="checkbox"/> | _____              |
| Tagamet/other antacids       | <input type="checkbox"/> | <input type="checkbox"/> | _____              |
| Thyroid medication           | <input type="checkbox"/> | <input type="checkbox"/> | _____              |
| Valium/tranquilizers         | <input type="checkbox"/> | <input type="checkbox"/> | _____              |
| Alcohol (in excess)          | <input type="checkbox"/> | <input type="checkbox"/> | _____              |
| Tobacco                      | <input type="checkbox"/> | <input type="checkbox"/> | _____              |