



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

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fertilegroundwellnesscenter@gmail.com

## Lactation Support Intake Form

Mother's 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 \_\_\_\_\_

Do you plan to return to work?  Yes  No Return Date \_\_\_\_\_

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

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 \_\_\_\_\_

**Primary Concern**

I need help with the following (please be as specific as possible)

What have you tried so far to help with this?

**Baby's Information**

Baby's Name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Born at \_\_\_\_\_ weeks

Birth Weight \_\_\_\_\_ Lowest Weight \_\_\_\_\_ Current Weight \_\_\_\_\_

\_\_\_\_\_ # Wet diapers per 24 hours \_\_\_\_\_ # Dirty diapers per 24 hours

Jaundice?  Yes  No Highest Bili \_\_\_\_\_

Pediatrician \_\_\_\_\_ Phone \_\_\_\_\_

**Pregnancy Information**

Please describe your pregnancy experience (normal, difficult, complications, etc):

**Labor and Delivery Information**

Where was your baby born? \_\_\_\_\_

Attending Obstetrician/Midwife \_\_\_\_\_ Phone \_\_\_\_\_

Doula or other labor assistant \_\_\_\_\_ Phone \_\_\_\_\_

Type of Delivery:  Vaginal  C-Section

Medications during delivery:

- Epidural
- Spinal
- Pain Meds (what kind?)
- Pitocin
- Antibiotics
- Other \_\_\_\_\_

Were there complications during delivery?  Yes  No

*If yes, please check all that apply:*

- Forceps
- Vacuum
- Fetal Diseases
- NICU admission
- Other: \_\_\_\_\_

## Maternal History

Do you have other children?  Yes  No

If yes, how many? \_\_\_\_\_ Did you breastfeed?  Yes  No

Have you had breastfeeding issues in the past? (please explain):

*Please check below all that apply to you:*

- Thyroid Problems
- Diabetes (including gestational)
- Smoker
- Hormonal disorder/cystic ovaries
- Hypertension/swelling post-delivery
- Depression
- Breast surgery
- Chronic conditions

Current medications or over-the-counter drugs

Do you have allergies? What are you allergic to?

Does the father have allergies? What is he allergic to?

Please describe your average daily diet and fluid intake:

What is your current nursing "schedule", if any? How many feedings per day?

Do you feel "let down" or heavy sensations in your breasts while feeding?  Yes  No

Are you using a pump?  Yes  No If yes, what kind? \_\_\_\_\_

Are you supplementing with formula or donated breast milk?  Yes  No

If pumping or supplementing, what type of bottle are you using? \_\_\_\_\_