CANCELLATION & RESCHEDULING POLICY

We understand that there are times when you will need to cancel and/or reschedule your appointment.

We are pleased to accommodate your needs. It is our policy, however, that all cancellations and/or rescheduled appointments take place 24 hours prior to the date of your originally scheduled appointment.

A fee of $50 will be charged if this policy is not honored.

Thank you for your understating.

Please sign here indicating that you understand and accept this policy:

____

Patient Signature

____

Date

ADVICE TO CONSULT A PHYSICIAN

I, ______________________, affirm that I have been advised by Patti Safian M.S. LAc, CA, to consult a physician regarding the condition or conditions for which I am seeking acupuncture treatment. By signing below, I acknowledge receipt of this document.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Patti Safian M.S. LAc, CA Date

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future treats me while employed by, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office or clinic.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine and nutritional counseling.

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases of dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then know, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

By signing below, I agree to the above-named procedures. 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.

To be completed by the patient:

Patient's Name: ______________________________

Signature: ______________________________

Date: ____________________

Are you pregnant? Yes No Maybe

To be completed by the patient's representative, if necessary, e.g. if the patient is a minor or is physically or legally incapacitated:

Patient's Name: ______________________________

Patient's Representative: ______________________________

Relationship of Authority: ______________________________

Witness: ______________________________

______________________________ ____________________

Patti Safian M.S. LAc, CA Date

INTAKE FORM

Please answer the following questions to the best of your ability to enable a more complete assessment of your condition.

Date: ____________

Name: ______________________________

Address 1: ______________________________

Address 2: ______________________________

City: ______________________ State: ________ Zip: __________

Daytime phone: ____________ Home phone: ____________ Cell phone: ____________

E-mail address: ______________________

Gender: Female / Male Birthdate: ____________ Place of Birth: ___________

Marital status: ______________

Height: __________ Weight: _________

Profession: ____

How were you referred?

Friend _____________ Relative _____________ Seminar _________ Internet_________

Other______________

Who is your current Reproductive Endocrinologist? ____________________________

YOUR MEDICAL HISTORY

Please check ALL that apply.

____Engage in safe sex

____HIV risk: self or partner

____TB risk: self or partner

____Hepatitis: self or partner

____Blood transfusions

Please answer the following questions.

1. Please describe in detail the main problem(s) you would like to address. Include the onset, progression, aggravating and alleviating factors. How does this condition affect your life? Please rank your problem on a scale of 1 to 10 (where 1 is mild and 10 is severe):

2. On a scale of 1 to 10, how is your energy level (1 being the worst and 10 being the best)? Do you experience an energy slump at any particular time of day?

3. Urination: Do you experience any frequency, urgency, burning, dribbling? Do you notice any abnormal coloration? Do you have a history of urinary tract infections or other urinary dysfunction?

4. Bowel movement: Are they regular, once a day, twice a day, every other day, etc.? Do you ever experience diarrhea, constipation, alternation of the two, etc.? Any history of large intestine problems?

5. Do you experience any sensations of heat or cold? Do you prefer warmth, lots of sweaters and blankets? Or are you comfortable wearing T-shirts during colder weather?

6. How is your appetite? Are you hungry only at mealtimes? Or, more of less often?

7. Do you have any abnormal thirst, dry mouth or throat?

8. Do you experience night sweats? Sweating upon slight exertion?

9. Please describe in general what you eat. Do you eat a lot of sweets or any other particular foods? Do you crave salty foods? Sweets?

10. Do you experience digestive difficulties? Do you experience any bloating, reflux, gas or ulcers?

11. Do you have any known heart problems? Do you experience heart palpitations or fluttering?

12. Do you have any respiratory problems such as asthma, etc.? Do you experience shortness of breath?

13. Do you have ringing in the ears, low or high-pitched? Stuffy sensation in the ears?

14. Do your eyes ever burn, itch or tear? Do they feel gritty or dry? Do you have floaters (spots) before your eyes?

15. Do you fall asleep easily or have initial insomnia? Do you wake up in the middle of the night and have difficulty falling asleep again? Do you wake up feeling rested? Do you have vivid dreams or nightmares? Do your dreams center around any particular themes and if so, what?

16. Do you have a propensity to catch colds or get sick frequently?

17. If you smoke, consume alcoholic or caffeinated beverages, and/or engage in any other recreational drugs, please describe frequency and amount.

18. Please list all herbs and supplements you are currently taking along with dosage.

GYNECOLOGIC HISTORY

When was the first day of your last period? ____________________

Are your periods regular? Yes _____ No _____

Age at first period? _____ #Days between periods? _____ #Days of bleeding? _____

Amount of bleeding: Light _____ Medium _____ Heavy _____

Have you ever needed medication to bring on your period? Yes _____ No _____

Pain with menstruation? Yes _____ No _____

Degree of pain: Mild _____ Moderate _____ Severe _____

Pain relieved by over the counter medications? Yes _____ No _____

Starts with the onset of bleeding? Yes _____ No _____

Begins a few days prior to the onset of bleeding? Yes _____ No _____

Persists more than 48 hours? Yes _____ No _____

Do you have pain with ovulation? Yes _____ No _____

Do you experience pain with sexual intercourse? Yes _____ No _____

Pain is mostly on the exterior? Yes _____ No _____

Pain is mostly internal (deep penetration)? Yes _____ No _____

Do you experience painful ovulation? Yes _____ No _____

Are you experiencing a vaginal discharge? Yes _____ No _____

Associated with itching or burning? Yes _____ No _____

Associated with an unusual odor? Yes _____ No _____

Do you have a Gynecologist? Yes _____ No _____

When was your last Pap Smear? ____________________

Result? ____________________

If yes, what follow up was needed? ____________________

Have you ever had a Mammogram? Yes _____ No _____

Have you ever had a sexually transmitted disease? Yes _____ No _____

Chlamydia, Gonorrhea, Syphilis, Herpes, Other ______________

When? ____________ Was it treated? Yes _____ No _____

Have you ever had Pelvic Inflammatory Disease (PID)? Yes _____ No _____

When? ____________________

Were you Hospitalized? Yes _____ No _____

Do you experience milk or discharge from your breasts? Yes _____ No _____

Have you ever used an IUD? Yes _____ No _____

Have you ever used the Oral Contraceptive Pill? Yes _____ No _____

How many years? ____________________

When did you last use it? ____________________

PREVIOUS SURGERIES

Have you ever had surgery?

Procedure	Date	Indication	Outcome

OBSTETRICAL HISTORY

Have you ever been pregnant before? Yes _____ No _____

Are you currently pregnant: Yes _____ No _____ Don't know _____

How long have you been trying to have a baby? ______ Years

Date	Current/ Prior Partner	Live Birth (Y/N)	Miscarriage/ Abortion/ Ectopic	Wks	Fetal Heart (Y/N)	D&C (Y/N)	Mode of Delivery	Sex	Wt.	Complications/ Comments

MEDICAL CONDITIONS

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

Condition	Yes/No	Comments
German measles (Rubella)	Yes No	
Migraine	Yes No	
Prolonged dizziness	Yes No	
Glasses/contact lenses	Yes No	
Thyroid problems	Yes No	
Pneumonia	Yes No	
Tuberculosis	Yes No	
Asthma	Yes No	
Bronchitis	Yes No	
Other lung conditions	Yes No	
Heart attach	Yes No	
Heat murmur	Yes No	
Rheumatic fever	Yes No	
Other heart conditions	Yes No	
High blood pressure	Yes No	
Gastric/duodenal ulcer	Yes No	
Hepatitis	Yes No	
Cirrhosis	Yes No	
Intestinal bleeding	Yes No	
Bleeding tendency	Yes No	
Problems with anesthesia	Yes No	
Diabetes	Yes No	
Kidney stones	Yes No	
Kidney infection	Yes No	
Other kidney disorders	Yes No	
Bladder infection	Yes No	
Rheumatoid arthritis	Yes No	
Other forms of arthritis	Yes No	
Lupus erythematosis	Yes No	
Paralysis	Yes No	
Neurological disorders	Yes No	
Thrombophlebitis	Yes No	
Varicose veins	Yes No	
Breast tumor (benign)	Yes No	
Breast Cancer	Yes No	
Ovarian Cancer	Yes No	
Uterine Cancer	Yes No	
Other	Yes No	

Please answer the following:

List all major emotional events in your life and approximately when they occurred. Please include any emotional events, whether or not you think they are major, that occurred within 6 months of the onset of your chief complaint. If there was an event, but you do not want to disclose it, please indicate that and the approximate date.

How often have you taken antibiotics?

	<5 times	>5 times
Infancy/Childhood		
Teen		
Adulthood		

How often have you taken oral steroids?

	<5 times	>5 times
Infancy/Childhood		
Teen		
Adulthood		

Your childhood experiences:

When your mother was pregnant with you, did she:	Yes	No	Don't know	Comment
a. Smoke Tobacco?				
b. Drink alcohol?				
c. Take estrogen?				
Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
As a child, did you eat a lot of sugar?				

Please add anything else you feel we should know:

FAMILY MEDICAL HISTORY

Is there a history of any of the following conditions in the family?

Condition	Yes/No	Comments
Diabetes	Yes No	
Heart disease	Yes No	
High blood pressure	Yes No	
Kidney disease	Yes No	
Multiple births	Yes No	
Mental retardation	Yes No	
Birth defects	Yes No	
Inherited diseases	Yes No	
Rheumatoid arthritis	Yes No	
Mental Illness	Yes No	
Cancer	Yes No	
Allergies (ie, food, dust)	Yes No	
Drug abuse	Yes No	
Thyroid disease	Yes No	
Lupus erythematosis	Yes No	
Blood disorders	Yes No	
Breast Cancer	Yes No	
Ovarian Cancer	Yes No	
Uterine Cancer	Yes No	
Other Cancer	Yes No	
Sickle cell disease	Yes No	
Cystic fibrosis	Yes No	
Tay Sachs	Yes No	
Thalassemia	Yes No	
Other	Yes No	
Other	Yes No	
Other	Yes No	

Signature: ______________________________ **Date:** ________________

MALE MEDICAL HISTORY

Occupation: ______________________________

1. Have you initiated any pregnancies in the past? Yes No
   - Number of pregnancies? ________
   - Number with current partner? ________
   - When was the most recent pregnancy? ________
2. Have you been evaluated by an Urologist? Yes No
   - If yes, what was the diagnosis? ______________________________
3. Have you ever had a semen analysis? Yes No
   - If yes, when? ________ (date). Please provide the following results of the analysis.
     - Count (Million cell/ml) ________ Motility (%) ________
     - Morphology (% normal forms) ________ Other ________
4. Are you allergic to any medications? Yes No
   - Medication: ____________________ Reaction: ____________________
5. Are you taking any medications? Yes No
   - Medication: ____________________ Dose: ________ Frequency: ________
   - Medication: ____________________ Dose: ________ Frequency: ________
6. Do you use tobacco? Yes _____ No _____ # Packs/day _____
7. Do you use alcohol? Yes _____ No _____ # Drinks/wk _____
8. Do you use a hot tub? Yes _____ No _____ # Times/wk _____

9. Have you ever had any of the following tests or procedures?

Test/Procedure	Date	Result	Comment
Blood Tests			
FSG			
LH			
Testosterone			
TSH			
Antisperm antibodies			
DQ Alpha			
Semen Tests			
Hamster egg penetration			
Fructose			
Semen culture			
Male Surgery			
Vasectomy			
Vasectomy reversal			
Testicular biopsy			
Varicocele ligation			
Hernia repair			
Undescended testicle			
Removal of testicle(s)			
Other			