**SOUTH** 143, 14919 Deer Ridge Dr. SE, Calgary T2J 7C4
**Tel:** 403.455.8029 **Email:** south@holisticinstitute.ca

**NORTH** 150, 4411 16th ave NW Calgary, AB T3B 0M3
**Tel**: 403.984.3970 **Email**: north@holisticinstitute.ca

# ACUPUNCTURE FERTILITY PATIENT INTAKE FORM

| Date: | | | | | |
|---|---|---|---|---|---|
| Surname: | | Pref Name: | | | |
| Date of Birth (M/D/Y): | | Age: | | Gender Pronoun: | |
| Address: | | | | | |
| City: | | Province: | | Postal Code: | |
| Family Doctor: | | | | | |
| Business Employer: | | Occupation: | | | |

**Phone/Contact Information**

| Home: | | Business: |
|---|---|---|
| Cell: | | Email: |

**How were you referred to us?**

| |
|---|
| |

**Have you heard about our HIHF health PROGRAMS?** _________yes _________no

**Would you like more information?** _________yes _________no

| **Please provide the reason for your visit:** | |
|---|---|
| | |
| | |
| | |
| Have you consulted with a physician or dentist (as appropriate) about the condition for which treatment is now being sought? | |
| What was their diagnosis? | |
| Is there anything that makes it better? | |
| Is there anything that makes it worse? | |

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# MEDICAL HISTORY

*List any medications or nutritional supplements that you are currently taking:*

| Name of Medication/ Supplement | Used for? | For how long? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Personal Health History** (*Please check any conditions or symptoms that apply to you*)

| | | |
|---|---|---|
| ❒ Addiction (s) | ❒ Aids | ❒ Anemia |
| ❒ Arthritis-Rheumatoid/Osteo | ❒ Asthma | ❒ Candida |
| ❒ Fibromyalgia | ❒ Migraines | ❒ Chronic Pain Condition |
| ❒ Crohn's Disease | ❒ Chronic Fatigue | ❒ Cholesterol Issues |
| ❒ Common Allergies | ❒ Diabetes I or II | ❒ Diverticulitis |
| ❒ Gastritis/Pancreatitis | ❒ Heart Disease | ❒ Hepatitis |
| ❒ High / Low Blood Pressure | ❒ HIV+ | ❒ Hives |
| ❒ Hypo / Hyperglycaemia | ❒ IBS | ❒ Impotence |
| ❒ Infertility | ❒ Insomnia | ❒ Kidney Issues |
| ❒ Liver / Gall Bladder Disease | ❒ Osteoporosis | ❒ Prostate |
| ❒ Fibromyalgia | ❒ Heart Disease | ❒ Mumps |
| ❒ Seizures / Epilepsy | ❒ Skin Disorders | ❒ Stroke |
| ❒ TB | ❒ Thyroid Imbalance | ❒ Ulcer |

| | |
|---|---|
| ❒ Cancer type: | |
| ❒ Food Allergies /Intolerance**:** | |
| ❒ Counselling: current or past in relation to today's visit | |
| ❒ Other: | |

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| **GYNAECOLOGICAL / REPRODUCTIVE HISTORY** | | | |
|---|---|---|---|
| Birth control? | ❒ Yes ❒ No | How long? | Type? |
| Age of first period? | | Date of your last period? | |
| Duration of period? (days) | | Length of cycle? (days) | |
| Are cycles regular? | ❒ Yes ❒ No | Painful menses? | ❒ Yes ❒ No |
| How heavy is your bleeding? | | ❒ Light ❒ Normal ❒ Heavy | |
| What color is the blood? | ❒ Light red ❒ Red ❒ Dark Red ❒ Purple ❒ Brown ❒ Black | | |
| Is there clotting? If yes, are they | | ❒ big clots ❒ small clots ❒ tissue | |
| Do you bleed or spot in between periods? | | ❒ Yes ❒ No | |
| Are you pregnant, if “yes” how many weeks? | | ❒ Yes ❒ No Number of weeks________________ | |
| Do you have a midwife, OBGYN, Doula? (Circle one) | ❒ Yes ❒ No | Breast pain, lumps? | ❒ Yes ❒ No |
| Endometriosis? | ❒ Yes ❒ No | Cervical Dysplasia? | ❒ Yes ❒ No |
| Ovarian cysts, fibroids? | | ❒ Yes ❒ No | |
| How many children to do have? | | Number: | Years: |
| How many pregnancies have you had? | | Number: | Years: |
| How many abortions have you had? | | Number: | Years: |
| How many miscarriages have you had? | | Number: | Years: |
| How many times has a D&C been performed? | | Number: | Years: |
| Have you ever had an abnormal pap smear? | | ❒ Yes ❒ No | |
| Have you ever had a venereal disease? Name of disease? | | ❒ Yes ❒ No | |
| Do you get yeast infections regularly? | | ❒ Yes ❒ No | |
| Have you ever had pelvic inflammatory disease? | | ❒ Yes ❒ No | |
| Have you ever been diagnosed with any pelvic abnormalities? | | | ❒ Yes ❒ No |
| Do you get premenstrual back pain? | | | ❒ Yes ❒ No |
| Do your bowel movements become loose at the beginning of your period? | | ❒ Yes ❒ No | |
| Menopausal symptoms? | | ❒ Yes ❒ No | |

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## FERTILITY QUESTIONNAIRE

PLEASE "TICK" IF APPLICABLE

**WOMEN**

| | | | |
|---|---|---|---|
| ____ | No Ovulation | ____ | Fallopian Tube Block |
| ____ | Irregular Periods | ____ | Uterine Fibroids |
| ____ | Thin Endometrium | ____ | Ovarian Cysts |
| ____ | Poor Quality of Eggs | ____ | Endometriosis |
| ____ | Poor Quantity of Follicles | ____ | Adhesions |
| ____ | Low Estradiol/Progesterone | ____ | Ectopic pregnancy |
| ____ | High FSH | ____ | Reproductive Infections |
| | Short Luteal Phase | | |

**MEN**

| | | | |
|---|---|---|---|
| ____ | Sexual Issues | ____ | Abnormal Morphology |
| ____ | Minimal/Premature/ No Ejaculate | ____ | Varicocele |
| ____ | Autoimmunity | ____ | Blockage in Duct |
| ____ | Small Testicles | ____ | Vasectomy |
| ____ | Hormone Issues | ____ | Infection |
| ____ | Low Sperm Volume, Count, quality | ____ | Injury to Scrotum/Testicles |
| ____ | Abnormal Motility | ____ | PCOS |

**IVF/IUI**

Approximate date of retrieval

Approximate date of transfer

Medications

Date Medications Started

ANY OTHER CONCERNS?

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**Male Reproductive History** ♂

List all medications you are taking including all prescriptions, beta blockers, anti-fungal, anti-inflammatory, prostate meds etc.

List all vitamins, herbs, supplements you are taking including any for weight lifting or body building.

List all medicated creams and shampoo you are using.

How much caffeine do you consume a day? Including coffee, teas, pop

How much alcohol a day? A week?

What is the consistency of your ejaculate? ☐ Watery ☐ Thick ☐ Bloody ☐ Scarce ☐ Normal

Have you experienced leaky ejaculate? ☐Yes ☐No

Do you experience spontaneous ejaculation? ☐Yes ☐No

Do you experience premature ejaculation? ☐Yes ☐No

Do you ejaculate when you are sleeping? ☐Yes ☐No

Have you experienced any scrotal or testicular injury, including a vasectomy? ☐Yes ☐No

Do you experience scrotal swelling, lumps or itchiness? STDs? ☐Yes ☐No

Do you experience any cold sensation in your scrotum or testicles? ☐Yes ☐No

Is there lack of firmness in your erection? ☐Yes ☐No

Any concerns regarding impotency or erectile dysfunction? ☐Yes ☐No

Do you experience any penile pain? Pain upon urinating? ☐Yes ☐No

Have you ever tested for issues concerning:

☐ Sperm Count ☐ Sperm Mobility ☐ Sperm Morphology/Shape ☐ Prostate

What was the diagnosis? ____________________________________________

________________________________________

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## GENERAL TCM HEALTH HISTORY

**During the day do you feel:**
❒ Chills ❒ Fever ❒ Both
❒ Perspiration when not active

**Do you prefer to drink:**
❒ Warm / hot fluids ❒ Cold fluids

**Are you frequently thirsty?**
❒ Yes ❒ No ❒ Sometimes

**How much water do you drink in a day? ________**

**How is appetite?**
❒ Good ❒ Normal ❒ Poor
❒ I experience "gnawing hunger"

**After eating do you experience?**
❒ bloating ❒ gas ❒ acid regurgitation
❒ fatigue / sleepiness ❒ cravings for sweet / salty

**At night, I:**
❒ have difficulty falling asleep
❒ have difficulty staying asleep – if so, what times are you waking up?
❒ have dreams that wake me up
❒ waking feeling hot / sweaty
❒ feel anxious*
❒ have heart palpitations*
**Please indicate if during the day too*

**Urine:**
❒ I wake during the night to urinate
❒ I urinate first thing when I awake
❒ unusual color
❒ unusual odour
❒ any mucus in your urine?
❒ any burning sensation?
❒ do you have frequent urination?
❒ have an urgency to urinate?

**Bowel Movements:**
❒ constipated ❒ diarrhea ❒ both
❒ frequency ❒ unusual odour ❒ mucus
❒ runny ❒ dry ❒ bloody
❒ urgency to go first thing in the a.m.

**Pain?** *Please describe if sharp, dull, achy, hot, cold, shooting, moving*
❒ in your back ❒ lower, middle, upper
❒ in your knees
❒ tension in your shoulders / neck
❒ headaches – what areas of head?
❒ migraines – caused by the change in weather?
❒ in your heels when you walk
❒ shoulders
❒ arms
❒ hands
❒ legs
❒ feet
❒ other

**Respiratory?**
❒ any breathing difficulties
❒ difficulty taking deep breaths

**Hair / Teeth / Eyes?**
❒ have you experienced hair / teeth **loss**?
❒ have you experienced excess hair **growth**/where
❒ premature greying?
❒ do you clench or grind your teeth?
❒ do your eyes get dry, blurry, strained when tired?
❒ do you see floaters?

**Energy?**
❒ are you frequently tired
❒ have normal energy levels
❒ better than normal

***Office use only***

| PULSE R | | PULSE L | | TONGUE | |
|---|---|---|---|---|---|
| LU | | HT | | | |
| SP | | LV | | | |
| KI YANG | | KI YIN | | | |

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Please CIRCLE areas of pain/ discomfort

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## HIHF CLINIC CANCELLATION POLICY

We understand at the Holistic Institute of Health and Fertility (HIHF) that unplanned events can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

We want to be available for your needs and the needs of all our clients. When a client does not show up for a scheduled appointment, another client loses an opportunity to be seen. In the event of a missed appointment or an appointment cancelled within less than 24 hours notice, you will be charged the **FULL FEE.**

MasterCard, Visa and American Express are accepted at the clinic. Your credit card number will be kept on file to book/hold your appointment. Your credit card will only be charged should an appointment be missed without notifying the HIHF clinic.

Please indicate your acceptance of this policy by signing below. You are a valued patient, thank you for your understanding and cooperation.

Signature: _______________________________ Printed Name: _____________________________

Date: ______________________________

*Signature of Parent or Guardian if the Patient is under 18 years of age:* _____________________________

## HIHF CLINIC WAIVER

I understand that it is my choice to be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by the Holistic Institute of Health and Fertility (HIHF) is based on traditional Chinese medicine, and/or therapeutic massage, and/or yoga principles only and does not constitute a Western Medical diagnosis. I understand that I am not to rely on these therapeutic diagnosis and treatments as my sole remedy for the treatment I am seeking. I understand there may be some minor risks associated with these therapies including but not limited to slight bleeding, bruising, and mild dizziness. I understand clinic staff may review my records but all information will be kept confidential and will not be released without my written consent. If no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a Western Medical doctor. Further, if I am concurrently undergoing Western Medical treatments, it is my responsibility to advise my physician of any of these therapies and/or herbal supplements I am concurrently taking. I assume all risks and responsibilities for myself and release HIHF clinic and its agents from any injury or liability that may occur during a treatment session.

**Please sign and date below to indicate that you have read and understood this form.**

Signature: _______________________________ Printed Name: ______________________________

Date: ______________________________

*Signature of Parent or Guardian if the Patient is under 18 years of age:* _____________________________