South Shore Acupuncture and Fertility Wellness
Roberta Klein-Siegelson, MS, LAc
68 Merrick Road
Lynbrook NY 11563
(516) 596-1011

Date_____ Name_____

Date of Birth_____ Age_____ Sex_____

Address_____

City_____ State_____ Zip _____

Home Phone_____

Cell Phone_____

Work Phone_____

Please circle above preferred contact #

E-mail_____

Marital Status_____ Occupation_____

Emergency Contact Person_____ Phone #_____

Have you had acupuncture before? Yes No

Who may we thank for referring you? _____

Please check if you have had any of the following:

Heart condition_____ Autoimmune disease_____ Asthma_____

Diabetes_____ Dizziness/fainting____ Seizures____

Cancer_____ Alcoholism/Drug addiction_____ Arthritis_____

Stroke_____ High/Low blood pressure_____ Depression____

Hepatitis_____ Skin disease/disorder_____ Anxiety_____

Mental illness____ Thyroid condition_____ Migraines_____

Please list any allergies

_____

_____

Any additional medical history

_____

_____

_____

Please list any family medical history

_____

_____

_____

Please list current medications (prescription and over the counter)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list supplements/vitamins/herbs you are currently taking

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please check all that apply

Cigarettes_____ How much_____ Coffee_____ How much_____

Alcohol_____ How much_____ Soda_____ How much_____

Drugs_____ How much_____

Please list all types and frequency of exercise

_____

_____

Do you have any health concerns other than infertility?

_____

_____

Do you experience headaches?

Are you thirsty?

How much water do you drink in a day? Do you prefer your drinks warm, cold, room temperature?

How often do you have bowel movements? Are they formed, loose, hard, difficult to pass, alternating diarrhea and constipation?

Do you have urinary frequency, burning, dribbling? Is your urine dark or light in color? Is it cloudy? Do you have a history of urinary tract infections?

How is your sleep? Do you fall asleep easily? Do you wake during the night? Vivid dreams? How many hours do you sleep per night?

Which of the following best describes you? Choose as many as you want-

Stressed, worried, anxious, depressed, irritable, impatient, sad, angry, fearful, other.

Please check all symptoms that apply to you. You can add comments to clarify if you wish.

_____Fatigue
_____Fatigue after eating
_____Low appetite
_____Excessive appetite
_____Overweight
_____Bloated after eating
_____Crave sweets
_____Loose stool/diarrhea
_____Digestive problems
_____Feel heavy and sluggish
_____Heaviness in your head
_____Bruise easily
_____Poor circulation
_____Varicose veins
_____Worry frequently
_____Low blood pressure
_____Sweat without exertion
_____Frequently sick?
_____Seasonal allergies
_____Hypothyroid
_____Anemia
_____Yeast infection
_____Cold nose
_____Hemorrhoids
_____Menstrual blood thin watery and pinkish
_____Spotting midcycle or prior to a full menstrual flow
_____Uterine prolapsed
_____Bearing down sensation type menstrual cramps

_____Depression
_____Anger/frustration
_____Sigh a lot
_____Irritable
_____Acid reflux/burning
_____Abdominal bloating
_____Feeling of lump in the throat
_____Lumps in your groin
_____Vision problems
_____Red,dry,itchy eyes
_____Migraines
_____Brittle nails
_____Pain around and under ribcage
_____Premenstrual irritability
_____Bloated/irritable around ovulation
_____Premenstrual breast tenderness/swelling/breast lumps
_____Elevated prolactin levels
_____Premenstrual bloating
_____Menstrual cramps BEFORE your period begins
_____Menstrual blood thick, dark, purplish color
_____Menstrual blood contains clots/tissue
_____Irregular menstrual cycle

_____Dizziness

_____Insomina

_____Vivid dreams

_____Dry eyes/floaters

_____Blurred vision/poor night vision

_____Muscle spasms

_____Low blood pressure

_____Dry skin

_____Losing your hair

_____Poor memory

_____Very light menstrual flow or lack of period

_____Do you get dizzy or lightheaded around your period

_____Menstrual cramps AFTER your period begins

_____Trouble falling asleep/staying asleep

_____Vivid dream/nightmares

_____Palpitations

_____Easily startled

_____Anxious

_____Restless/agitated

_____Do you fidget

_____Warm palms and soled

_____Flush easily

_____Chest pain/tightness

_____Tongue/mouth sores/canker sores

_____Bitter taste in mouth

_____Forgetful

_____Varicose or spider veins

___Lower abdomen tender to the touch

_____Abdominal lumps

_____Fixed or stabbing headaches

_____Pain around and under ribcage

_____Numbness of hands and feet

_____Very dark brown or purple menstrual blood

_____Menstrual blood contains clots

_____Midcycle pain around ovaries

_____Painful breasts

_____Breast lumps

_____Endometriosis/Fibroids

_____Weak/sore low back/knees

_____Ear ringing/loss of hearing

_____dizziness/vertigo

_____Hair prematurely gray/ hair loss

_____Night sweats

_____Hot flashes

_____Fearful

_____Hot palms/soles/chest

_____Poor memory

_____Dark, scanty urine

_____Bones ache

_____Dark under eye circles

_____Frequent urination

_____High sex drive

_____Scanty or no midcycle cervical mucus

_____Vaginal dryness

_____Usually cold/colder than those around you

_____ Weak/sore low back/knees

_____Cold hands/feet

_____Low sex drive

_____Fearful

_____Wake at night to urinate

_____Frequent urination

_____Loose stool in early morning

_____Loose teeth

_____Dislike cold weather

_____Retain fluid

_____Ear ringing/hearing loss

_____Menstrual cramps that respond well to heat

_____Dry mouth/throat

_____Thirst for cold drinks

_____Often warmer than those around you

_____Acne/red acne

_____Short menstrual cycle

_____Vaginal irritation/rashes

_____Tired/sluggish after eating

_____Cystic/pustular acne

_____Achy joints

_____Sticky feeling in mouth

_____Bloated often

_____Experience nausea

_____Loose stool with urgency

_____Not thirsty

_____Heaviness in head/body

_____Retain fluid

_____Fibrocystic breasts

_____Menstrual blood contains stringy tissue

_____Prone to yeast infections

_____Diarrhea/loose stool with foul smell and urgency

_____Green or yellow vaginal discharge

_____Vaginal itching/infection

Date of last period_____ How old were you when you had your first period?_____

How many days do you normally bleed for_____ Menstrual cycle length (I.E. 28-30 days)_____

Describe your flow :Heavy Moderate Light Clots

Color of blood: (bright red, red, dark red, brown, purple, pink, etc.)_____

Consistency of blood :Watery Thick Sticky Average

Do you experience menstrual pain? Before period During After

Does anything relieve the pain (i.e. heat)

Type of pain: Stabbing Heavy/pulling Dull Cramping

Do you ovulate on your own?_____ What day in your cycle_____

Do you track ovulation: Ovulation predictor sticks Saliva Basal body temperature

Do you have clear stretchy egg white cervical fluid around ovulation?

Have you even been pregnant?____ How many times? ____

How many times have you given birth?____ Ages of children_____

Have you had any miscarriages?___ If so, at how many weeks and in what year(s)?_____

Have you ever had a D&C?_____ When?_____

Have you ever had an abortion?_____ When?_____

Any difficulties with previous pregnancies?_____

Have you ever been diagnosed with: STD Pelvic inflammatory disease Polyps
Endometriosis Fibroids Pelvic adhesions/scarring Polycystic Ovarian Syndrome
Uterine shape abnormality Abnormal pap cervical biopsy/procedure
Bladder/urinary tract infections Yeast infections

Have you taken birth control pills?_____ When and for how many years_____

Have you ever had an IUD?_____ Have you taken Depo-Provera?_____

How long have you been trying to conceive?_____

Have you been to a Reproductive Endocrinologist?_____

Who is your doctor/clinic_____ Have you received a diagnosis?_____

Have you had hormone testing? FSH Estrogen Progesterone Prolactin

Testosterone Thyroid Other

Were any of these lab values out of normal range?_____

_____

Have you had: Saline sonogram Hysterosalpingogram (fallopian tube evaluation)

Has your partner had a semen evaluation?____ What were the results?_____

Please list all Assisted Reproductive Procedures that you have had (include all fertility medications taken as well as procedures i.e.IUI, IVF) , dates and outcomes

_____

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Roberta Klein-Siegelson
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Office Policy

All fees are payable when services are rendered, by cash or check

Cancelling or rescheduling appointments:
24 hour notice is required for cancellation. You will be charged $30 for cancellations with less than 24 hours notice. Additionally, if you will be late for your appointment, please call us to let us know. If you arrive later than 10 minutes for your appointment, your appointment may need to be rescheduled. There will be a $30 charge for "no-shows" or missing your appointment without cancelling.

Insurance Policy

1. I agree that if my insurance sends me a check for acupuncture services rendered by Roberta Klein-Siegelson that I will immediately endorse and give the check to Roberta.
2. I agree that all deductible payments must be made prior to insurance submittal.
3. I agree that if my insurance refuses payment for treatment, due to any reason, that I am responsible for any outstanding balance for services that I have received.
4. I agree that I will immediately notify Roberta Klein-Siegelson if I receive any notification, written or verbal, that my insurance benefits will be discontinued.
5. I authorize Roberta Klein-Siegelson to release any information to my insurance company that is necessary to expedite the payment of claims.

If Roberta Klein-Siegelson is forced to send my account to a collections agency, I understand I will be charged the full balance of my account as well as any incurred collection fees.

Print Name_____

Signature _____

Date_____

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Informed Consent to Acupuncture Treatment

I consent to acupuncture treatment and other procedures associated with the practice of Traditional Chinese Medicine by Roberta Klein-Siegelson, Licensed Acupuncturist. I have discussed the nature and purpose of my treatment with her.

I understand that the methods of treatment may include, but are not limited to: acupuncture, cupping, moxibustion and electrical stimulation. I understand that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness and fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this office uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I will notify Roberta Klein-Siegelson immediately if I have any adverse reactions to any form of acupuncture, herbal therapy or other treatment received.

I will notify Roberta Klein-Siegelson immediately if I am, become, or am trying to become pregnant.

I do not expect Roberta Klein-Siegelson to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her to exercise her judgement during the course of treatment which she thinks at the time, based upon the facts known to her, is in my best interest. I understand that all of my records will be kept confidential and will not be released to any party without my written consent as per HIPAA regulations.

Roberta Klein-Siegelson recommends that you consult a physician for the condition for which you are seeking acupuncture treatment.

I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Print Name_____

Signature _____

Date_____