The Texas Center for Reproductive Acupuncture

Austin * San Antonio * Dallas

Personal Information

Name: ______________________ D.O.B. ________ Age: _____ Today's Date:_______

Address: ______________________________ City: ______________________

State: ______ Zip: _______ Primary Phone: _______________ Alt. Phone: _______________

E-mail: _________________ Occupation: _______________ Employer: _______________

In Case of Emergency, whom should we notify? _______________ Number: _____________

How did you hear about our office? ______________________________

Primary Health Care Provider: ___________________ Urologist: ______________________

Have you been given a medical diagnosis for your condition? ______________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered

Partner's Name: _________________ Partner's Age: ______ Occupation: _______________

Has your partner been given a fertility-related diagnosis? ______________________

Is your partner under the care of our clinic? ☐ Yes ☐ No If yes, what is their name? _______________

Do you have any biological children with your partner? ☐ Yes ☐ No | How many?_____ Age(s) ______

Do you have any biological children with a previous partner? ☐ Yes ☐ No | How many?_____ Age(s) ______

Medical Information

Have you had a semen analysis? ☐ Yes ☐ No | If yes, when was the most recent analysis? _____________

Results for Sperm Analysis:

Date	Count / mL / > 20	Total Count / > 40	Motility / > 50%	Morphology > 30% / 14%	Volume (2-5 mL)

Abnormal Leukocytes / Viscosity / Liquefaction: ______________________________

Have you ever had any of the following Exams or Procedures?

Sperm Chromatin Structure Assay (SCSA)	☐ Yes ☐ No	Vasectomy	☐ Yes ☐ No
Sperm Aspiration (MESA / TESA / PESA)	☐ Yes ☐ No	Prostate Exam	☐ Yes ☐ No
Anti Sperm Antibodies (ASA)	☐ Yes ☐ No	IVF with ICSI	☐ Yes ☐ No
Vasectomy Reversal	☐ Yes ☐ No		

Do you have any of the following symptoms either currently or in the past?

Irritable Bowel (IBS) or Chron's	☐ Yes ☐ No	Testicular Pain	☐ Yes ☐ No
Swelling of the testicles / scrotum	☐ Yes ☐ No	Cloudy Urination	☐ Yes ☐ No
Sensation of heat in the testicles	☐ Yes ☐ No	Hypospadia	☐ Yes ☐ No
Difficulty ejaculating	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No
Retrograde Ejaculation	☐ Yes ☐ No	Prostatitis	☐ Yes ☐ No
Erectile Dysfunction (ED)	☐ Yes ☐ No	Impotence	☐ Yes ☐ No
Testicular / scrotal itching	☐ Yes ☐ No	Vericocele	☐ Yes ☐ No
Poor or no sense of smell	☐ Yes ☐ No	Epididymitis	☐ Yes ☐ No
Difficulty urinating	☐ Yes ☐ No	Hernia	☐ Yes ☐ No

History of sexually transmitted disease (STD): ______________________________

Genetic or chromosomal abnormalities / translocations: ______________________________

____

Current supplements and/or medications:

____

____

General Health Information

Major Health Complaint(s). Other than your primary reproductive concerns, please list any health concerns or complaints that you have in order of their significance.

Major Health Complaints / Symptoms	Additional Health Complaints / Symptoms
1. ______________________	1. ______________________
2. ______________________	2. ______________________
3. ______________________	3. ______________________
4. ______________________	4. ______________________

Please explain how these conditions affect or impair your daily activities

____

____

Describe your symptoms when they are at their worst: ______________________

____

____

Are there any other complaints or conditions that you would like us to know about?

____

Medical Conditions and History: Check any conditions you currently have or have had in the past.

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Rheumatic fever
☐ Heart Disease	☐ Stroke	☐ Vein condition	☐ Thyroid disorder
☐ Asthma	☐ Pneumonia	☐ Tuberculosis	☐ Emphysema
☐ Mental Illness	☐ Measles	☐ Mumps	☐ Bleeding/Hemorrhage
☐ Kidney disease	☐ HIV	☐ Chicken Pox	☐ Nervous disorder
☐ Meningitis	☐ High Fever	☐ Polio	☐ Auto Immune Disease
☐ Epilepsy	☐ Cancer	☐ Hepatitis	☐ Hypertension
☐ Paralysis	☐ Chlamydia	☐ Migraines	☐ Mental Illness
☐ Lung disease	☐ Liver disease	☐ Kidney disease	
☐ Gonorrhea	☐ High Cholesterol		

Please check any of the following symptoms that currently pertain to you:

Body Temperature (Kidney Organ System)

☐ Cold hands	☐ Hot body temperature	☐ Profuse perspiration	☐ Perspire easily
☐ Cold feet	☐ Cold body temperature	☐ Lack of perspiration	☐ Night time urination
☐ Sweaty palms	☐ Afternoon flushing	☐ Night sweating	
☐ Sweaty feet	☐ Hot flashes	☐ Strong thirst	

Energy and Stamina (Lung and Kidney System)

☐ Easily fatigued	☐ Lethargy	☐ Easily prone to illness	☐ Wheezing
☐ Shortness of breath	☐ Sweating	☐ Frequent colds/flus/sinuses	☐ Allergies

Blood Function (Liver, Heart and Spleen System)

☐ Dizziness	☐ Tingling in extremities	☐ Itchy or dry	☐ Blurry vision
☐ Poor night vision	☐ Poor memory	☐ Tinnitus	
☐ Floaters	☐ Difficulty concentrating	☐ Fainting	☐ Weak or brittle nails

Heart Function

☐ Heart palpitations	☐ Manic moods	☐ Forgetfulness	☐ Tongue ulcers
☐ Anxiety	☐ Restless dreams	☐ Hallucinations	☐ Speech impediment
☐ Mental restlessness	☐ Insomnia	☐ Depression	☐ Severe shyness
☐ Chest Pain	☐ Arrhythmia	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Hemophilia	☐ Rapid Heart Beating	☐ Heart Murmur	☐ Mitral valve prolapse

Lung Function

☐ Persistent cough	☐ Chronic allergies	☐ Dry or flaky skin	☐ Headaches
☐ Nosebleeds	☐ Nasal dryness	☐ Sneezing	☐ Difficulty breathing
☐ Sinus congestion	☐ Sore throats	☐ Wheezing	☐ Cigarette smoking

Allergies to:

☐ Mold ☐ Cedar ☐ Pet fur ☐ Dust ☐ Pollen ☐ Oak ☐ Hay Fever ☐ Environmentally Sensitive

If you are a smoker, # of cigarettes per day __________ How long have you been smoking? ______________

If you are a smoker, do you want to quit? ☐ Yes ☐ No [Level of determination to quit - 1 2 3 4 5 6 7 8 9 10]

Spleen Function

☐ Low or weak appetite ☐ Abdominal bloating ☐ Gurgling in intestines ☐ Hemorrhoids
☐ Abrupt weight gain ☐ Gas ☐ Fatigue following a meal ☐ Hypoglycemia
☐ Abrupt weight loss ☐ Strong food cravings ☐ Bruise easily ☐ Indigestion

Stomach Function

☐ Stomach ache ☐ Bad breath ☐ Stomach ulcer ☐ Nausea
☐ Acid reflux ☐ Bleeding gums ☐ Belching ☐ Vomiting
☐ Ravenous appetite ☐ Heartburn ☐ Hiccups ☐ Mouth ulcers

Bowel Function and Elimination (Intestinal Function)

☐ Loose stools ☐ Constipation ☐ I.B.S. or Colitis
☐ Diarrhea ☐ Blood in stools ☐ Small, hard, dry stools ☐ Chron's Disease
☐ Incomplete stools ☐ Mucous in stools ☐ Less than 1 BM/ Day ☐ Eating Disorder

Accumulated Dampness

☐ Mental fogginess ☐ Swollen hands ☐ Edema in the legs
☐ Mental sluggishness ☐ Swollen feet ☐ Edema in the abdomen
☐ Poor mental focus ☐ Joint stiffness / ache ☐ Chest congestion
☐ Heaviness of the head, the limbs, or of the whole body ☐ Symptoms worsen in rainy weather

Liver and Gall Bladder Function

☐ Chest pain ☐ Irritability ☐ Depression ☐ Skin rashes
☐ Chest tightness ☐ Easy to anger ☐ Pain in the ribcage ☐ Acne
☐ All over body tension ☐ Easily frustrated ☐ Heaviness in ribcage ☐ Headaches
☐ Muscle spasms ☐ Convulsions ☐ Chronic neck tension ☐ Migraines
☐ Muscle cramps ☐ Numbness / tingling ☐ Shoulder tension ☐ Gall stones
☐ Seizures ☐ Lump in throat ☐ Ringing in ears ☐ Eye pain / dryness
☐ Alternating diarrhea and constipation ☐ Easily overwhelmed by stressful circumstances

Eyes (Liver Function)

☐ Itchy eyes ☐ Grittiness ☐ Bloodshot ☐ Far sighted
☐ Dry eyes ☐ Poor night vision ☐ Seeing spots ☐ Astigmatism
☐ Watery eyes ☐ Red and irritated ☐ Near sighted ☐ Glaucoma

Kidney and Urinary Bladder Function

☐ Frequent cavities ☐ Weak knees ☐ Cold lower back ☐ Hair loss
☐ Broken / loose teeth ☐ Knee soreness ☐ Cold hips / buttocks ☐ Early graying of hair
☐ Weak bones ☐ Low back pain ☐ Cold knees ☐ Hearing loss
☐ Ringing in the ears ☐ Prostate problems ☐ Incontinence ☐ Quick to fear / fright

Urinary Function

☐ Normal color ☐ Reddish color ☐ Small amount ☐ Night-time urination
☐ Dark Yellow ☐ Cloudy ☐ Large amount ☐ UTI / Pain or burning
☐ Clear color ☐ Strong odor ☐ Very frequent ☐ Hesitancy
☐ Difficulty initiating the stream of urination ☐ Dribbling ☐ Weak stream

Libido Function

☐ Normal ☐ High sex drive ☐ Diminished sex drive ☐ DED
☐ Pain with ejaculation ☐ Fatigue following sexual activity ☐ Infertility

Medical Evaluation

I was evaluated by a physician, OB/GYN, reproductive endocrinologist, or chiropractor for the condition(s) being treated within the last 12 months.
☐ Yes ☐ No
I recognize that I should be evaluated by a physician for the condition(s) being treated by the acupuncturist.
☐ Yes ☐ No

Permission to maintain medical privacy and share medical information

All of the information that you provide to us is strictly confidential. It is our policy never to disclose any personal or medical information about any patients under our care without first obtaining your express permission to do so. There are, however, a few instances where we feel that sharing information about your case helps to provide the best possible clinical outcome, and we would like to ask your permission to share information in each of the following areas.

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1) The Texas Center for Reproductive Acupuncture is a multi-practitioner office. Each of the acupuncturists on our team is involved with every patient. During the course of your care with us, you may choose to schedule your visits with any of the acupuncturists on staff. Do you grant permission for your file and acupuncture records to be viewed and shared among all of the practitioners at The Texas Center for Reproductive Acupuncture?
☐ Yes ☐ No

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2) Many of our patients are under the care of an OB/GYN, a Reproductive Endocrinologist, or a Fertility Specialist. In an effort to maximize your clinical results, we may want to contact your Doctor(s), and send them periodic updates about your case and your progress. Do you grant your permission for us to discuss the details of your case with your OB/GYN, Reproductive Endocrinologist and/or Fertility Specialist? ☐ Yes ☐ No

______________________________ ________________
Patient Signature Date

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic 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. 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, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. 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.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _______. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE