Fertility Enhancement Program Intake Form
Dr. Maureen H. Rozenn, LAC., DAOM, FABORM

Today's Date_____

Name_____ Birth date_____

Address_____
Street City State Zip
Home Phone (____)_____ Work (____)_____ Cell (____)_____

Which phone number is best to leave messages on?_____

Main Concern_____

_____ For How Long?_____

Previous diagnoses (by M.D., etc.) _____

Other health concerns :
_____
_____

Who may we thank for your referral? _____

Have you ever had acupuncture or herbs?_____

Dietary Restrictions_____

Dietary Emphasis_____

Food Cravings_____

Allergies_____

Social Drugs, past or present (coffee, alcohol, sugar, tobacco, marijuana, etc.) and frequency of use:
_____
_____

Are you more than 20% over your ideal body weight? □ Yes □ No
Are you more than 20% below your ideal body weight? □ Yes □ No
Do you have a stressful occupation? □ Yes □ No
Do you exercise regularly? □ Yes □ No

On the reverse side, please list all medications, herbs, vitamins, and minerals you take even if you take them only occasionally AND THE DOSE.

How often do you move your bowels?_____

Do you tend toward constipation or diarrhea?_____

Any problems with gas, bloating or abdominal cramping?_____

Any blood, mucus or undigested food in the stool?_____

How many hours do you sleep at night? Time going to bed? Time getting up? _____

Do you feel rested in the morning? How is your energy during the day?_____

Age at which menses began _____

Are your periods painful? □ Yes □ No

How many days do you normally bleed? _____

How heavy is the bleeding? □ Light □ Normal □ Heavy
What color is the blood ?
□ Light red □ Red □ Dark Red □ Purple □ Brown □ Black
Is there clotting? □ Yes □ No
Do you have PMS? □ Yes □ No
Does your face break out before or during your period? □ Yes □ No
Do your breasts become tender premenstrually? □ Yes □ No
Do you bleed or spot between periods? □ Yes □ No
`If so, what cycle days do you typically spot? _____
Are your menstrual cycles spaced irregularly? □ Yes □ No
How many days are there from one period to the next? _____
What was the first day of your last menstrual period? _____
Have your cycles changed since they began? □ Yes □ No

How?_____

_____

Do you ovulate on your own? □ Yes □ No

On what day of your cycle? _____

Do your breasts get tender at/during ovulation? □ Yes □ No
Do you get premenstrual low back pain? □ Yes □ No
Do your bowel movements become loose at the beginning of your period? □ Yes □ No

How many pregnancies have you had? _____ When? _____

How many children do you have? _____ How old? _____

How many abortions have you had? _____ When? _____

How many miscarriages have you had? _____ When?_____

How many times has D&C been performed? _____ When? _____

Have you ever had an abnormal pap smear? □ Yes □ No
Have you ever had a cervical biopsy, LEEP, cauterization, or conization? □ Yes □ No
Have you ever had a sexually transmitted infection? □ Yes □ No

If so, which one(s)? _____

Do you get more than one yeast infection per year? □ Yes □ No
Have you ever been diagnosed with a chlamydial infection? □ Yes □ No
Do you have chronic vaginal discharge? □ Yes □ No
Do you have any sores on your genitalia? □ Yes □ No
Have you ever had pelvic inflammatory disease? □ Yes □ No
If so, were you treated for it? □ Yes □ No
If you were treated for PID, how and when?_____
Date of last Pap smear _____

Have you ever been diagnosed with uterine fibroids or polyps? □ Yes □ No
Have you ever been diagnosed with endometriosis? □ Yes □ No
Have you ever been diagnosed with pelvic adhesions? □ Yes □ No
Have you ever been diagnosed with any pelvic abnormalities? □ Yes □ No
Have you taken any medications for gynecological conditions other than birth control?

_____

Have you had fertility treatment? □ Yes □ No
If yes, when and where?
_____

What types?_____

Have you taken medication to help you ovulate? □ Yes □ No

When?_____ How long?_____

Did it work?_____

Have your fallopian tubes been evaluated medically? □ Yes □ No

What were the results?_____

Have you had any tubal operations? □ Yes □ No

Have you had any hormone laboratory tests performed? □ Yes □ No

What were the results?_____ Please attach a copy.

Do you have a single partner with whom you have been trying to conceive?
□ Yes □ No

How long have you been married or living together?_____

Is your partner supportive of your wish to conceive? □ Yes □ No
If your partner is male:
How old is he?
Has he fathered children from previous relationship(s)?_____How old was he at the time?_____
Has he had a fertility workup? □ Yes □ No

What were the results?_____

If no, is he open to taking a semen analysis test? _____

Have you taken oral contraceptives? □ Yes □ No

When and how long?_____

Have you ever had an IUD? □ Yes □ No

When and how long?_____

Have you ever taken Depo Provera? □ Yes □ No

When and how long?_____

How long have you been trying to conceive?_____

Have you had a diagnosis relating to infertility? □ Yes □ No

What was it?_____

How is your sexual energy? □ Low □ Normal □ High

Do you douche regularly? □ Yes □ No

With what?_____

Do you use vaginal lubricants? □ Yes □ No

Family History

Use a **C for a Current Problem** or a problem still present at the death of the individual indicated

Use an H if it is a historical condition that is not present now or was not present when person deceased

I understand that you may not be aware of these condition in many cases; leave these blank

Condition or Disease	Biological Father	Biological Mother	Spouse or Partner	Brother(s)		Sister(s)		Children	
AGE of Individual									
Asthma									
Hay fever/ Seasonal Allergy									
Food Allergy / Sensitivity									
Eczema									
Psoriasis									
Other Skin Disorder									
Diabetes I - Juvenile									
Diabetes II – Adult									
Hyperthyroid or Graves Disease									
Hypothyroid or Hashimotos									
Osteoporosis or Bone Problems									
Rheumatoid Arthritis									
Other Arthritis or joint pain									
Lupus or other Immune Disorder									
Liver Disease									
Hepatitis									
Gallbladder Removed									
Gallstones									
Kidney Stones									
Kidney disease									
Heart Disease or problem									
Stroke									
High Blood Pressure									
Cholesterol problems									
Cancer – Include Type									
Digestive Disorder									
Weight Problem									
Anorexia, Bulemia, Eating Disorder									
Crohns, Ulcerative Colitis, Colitis									
Irritable Bowel									
Chronic Constipation									
Alcohol Abuse or Excess									
Insomnia									
Anxiety									
Depression									
Other:_____ _____ _____ ___ _____ __									

Do you have excessively oily skin? □ Yes □ No
Have you experienced excessive loss of head hair? □ Yes □ No
Have you noticed discharge from your nipples? □ Yes □ No
Do you have any issues with blood sugar balance that you know of? □ Yes □ No
If yes, please explain:
_____
_____

Has your thyroid function been checked? □ Yes □ No When?_____

In a room full of people, do you often find yourself to be more warm or cold than the others?
□ Yes □ No Which?_____

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? □ Yes □ No
Have you been exposed to any known environmental toxins or hormones? □ Yes □ No
Are you presently taking steroids? □ Yes □ No
Are you presently taking NSAIDs (Advil, Tylenol, Aspirin, etc.)? □ Yes □ No

Please list any other comments or notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Chronological Life History

***Very Important! Please spend some time with this section and be as detailed as possible.

(examples: difficult birth such as premature delivery, C-Section, cord around your neck, etc., minor or major surgeries, broken bones, landmark emotional events, loss of consciousness...all the way from your birth to the present day)

First list age, then event

Endless Possibilities Acupuncture
845 Cedar Street
Santa Cruz, CA 95060
(831) 426-1093

HIPAA Notice of Privacy and Confidentiality & Patient's Rights

Patients' rights under HIPAA are described in the "Notice of Privacy Practices" The Notice will be made available to patients. These rights include:

Right to receive the 'Notice of Privacy Practices", which informs patients of their rights and how to exercise them. By law this notice is to be made available to patients, and a good faith effort to obtain the patient's acknowledgement of receipt is required.

Right of Access. Patients may request to inspect their medical record and may request copies. There may be a fee to produce the copiers. The process to follow and how to request copies is explained in the "Notice of Privacy Practices."

Right to Request and Amendment or Addendum. The Notice describes how to file a request for an amendment or addendum.

Right to an Accounting of Disclosures. Patients have the right to receive an accounting of disclosures of their Patient Health Information (PHI). The Notice describes how to request an accounting.

Right to Request Restrictions. Patients have the right to request restrictions on how they will be communicated with or how their PHI is released. Generally, every effort to try to accommodate reasonable requests for restrictions, e.g., where release of information could be harmful to the patient.

Right to Complain. Patients have the right to complain if they think that privacy rights have been violated. The "Notice of Privacy Practices" describes where to file a complaint.

Exceptions to the Rules

Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the "Notice of Privacy Practices". Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement, and based on a judicial request or subpoena.

Notice of HIPAA Privacy Practice

The attached Notice describes how health information about you may be used, and your rights, regarding the use of that informatio
Please review it carefully.

You have the right to:
Ask to see, read and/or obtain a copy of your health record (charges may be necessary)
Ask to correct information that you believe is wrong in your health record
Ask that your health information not be used for certain purposes, for example, research
Ask that copies of your health record be sent to whomever you wish (charges may be necessary)
Be informed about who has read your record (for reasons other than treatment, payment, and program improvement purposes).
Specify where and how you should be contacted
Receive a paper copy of the full Notice of Privacy Practices

Who is authorized to see confidential Patient Health Information (PHI)?
The "Notice of Privacy Practices" describes the ways in which your PHI may be used without obtaining the patient's specific authorization. Certain uses such as for Treatment, Payment and health care Operations are permitted.
Treatment of the patient, such as consultation between treating providers
Payment of health care bills (insurance claim submission, authorizations and payment posting)
Health care operations and business operations, including research (when approved by the IRB and with a patient's written permission); health care communications between a patient and their health care practitioner.

Written Authorizations
To use or disclose PHI for almost any other reason, you will need to sign a written authorization prior to access or disclosure. Refe to the "Notice of Privacy Practices" for a list of covered exceptions to the authorization requirement related to public policy, certain health disease reporting requirements and law enforcement activities. If you do not understand or know what you can do with PHI, please read the "Notice of Privacy Practices".

Exceptions to the Rules
Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the "Notice of Privacy Practices". Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement, and based on a judicial request or subpoena.

If you have concerns about how your health information might be (or has been) shared, please speak with your practitioner or the privacy coordinator. If you believe your privacy rights have NOT been maintained you may file a complaint with the Secretar the address is U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. You will not be penalized in any way for filing a complaint.

I acknowledge receipt of the "Notice of Privacy Practices" and "Patient's Rights". I understand that my signature does not authorize disclosure, but only acknowledges that I have received a copy of the full Notice.
I understand and acknowledge that I may receive appointment reminder calls, newsletters, and cards, and I agree to receive these.

Signature_____ Date_____Date of Birth_____

Printed Name_____ Relation (if other than the patient)_____

Patient declined to sign receipt (signature of practitioner)_____

Patent unable to sign (witness signature)_____Reason unable_____

Informed Consent to Acupuncture Treatment and Care

I hereby request and consent to the performance of procedures which are within the scope of a California license to practice acupuncture. This includes, but is not limited to, acupuncture treatments on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists or students who now or in the future treat me while working under, associated with, or serving as backup for Dr. Maureen Rozenn.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion(moxa) and heat therapy, cupping, electro-acupuncture, medical massage modalities such as Tui-Na or Mayan Abdominal Therapy, dietary supplements, herbal therapy, and nutritional counseling. Moxibustion and heat therapy including heat lamps, tiger warmers, cone, pole and Japanese moxibustion may cause discomfort and in rare cases may cause burns. I will alert the acupuncturist, or person supervisir the progress of my moxa treatment, immediately if any type of heat therapy is uncomfortable. The acupuncturist may choose to perform a form of moxibustion which consists of placing small rice sized pieces of moxa on an ointment barrier and lighting them to stimulate certain acupuncture points. I will decline the procedure if I do not wish to receive this or any other treatment.

I understand that acupuncture treatments are generally safe, but may have some side effects including bruising, numbness or tingling near the needling sites that may last a couple of minutes to a few days, dizziness or fainting, and nausea. I will notify the acupuncturist immediately if I feel uncomfortable at any time during or after treatment. There have been instances reported of spontaneous miscarriage and pneumothorax, although these side effects are very rare. Infection is another possible risk, although the acupuncturist only uses sterile, disposable acupuncture needles.

Herbs that have been used in treatment, or are recommended, are traditionally considered safe in the practice of Oriental Medicine, but may be toxic in large doses. Some of the possible side effects of taking herbs are: nausea, gas, hives, rashes, diarrhea, vomiting and tingling of the tongue. If I experience anything unusual during herbal treatment I will notify the acupuncturist immediately. I understand that some herbs and other therapies may be inappropriate during pregnancy. I will notify the acupuncturist if I think I may be pregnant.

Oriental medicine can be used to treat pregnant women for all sorts of disorders ranging from low back pain to the commor cold. I understand that while labor induction and pain management during labor are within the acupuncturist's scope of practice, sh does not specifically induce or treat women in labor. Treatment (pre-birth treatments) can be administered to prepare women for labor. Also, there are specific points and techniques traditionally used to help the mother promote correct fetal position. When treatment appropriate for my Chinese medical diagnosis is given during the last few weeks of pregnancy, or when past the due dat labor may start or a breech baby may turn. I understand this is a possibility and that if I am not willing to take this risk I will refuse treatment.

Cosmetic acupuncture results are not guaranteed. Facial skin is delicate and full of superficial blood vessels. Bruising can occur and scaring is a theoretical possibility.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expec the acupuncturist to be able to anticipate and explain all of the risks and complications. I wish to rely on the acupuncturist to exercis judgment and perform, during the course of my treatments, based upon the facts then known, the therapy that is in my best interes I understand that results are not guaranteed. 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 intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

Patient Signature_____Date_____
(Or Patient Representative)

Acupuncturist Signature_____Date_____

Terms of Care - Our Cancellation Policy

Please Read Carefully!

By signing below, I agree that I have read in full and will adhere to the following office policies without exemption:

- Patients are solely responsible for tracking and keeping any appointments scheduled online or via the front desk.
- If you are 15 or more minutes late, you have missed your appointment and are responsible for full payment of your appointment cost.
- If you're sick, please keep your appointment (we can help!). If you're too ill to drive, contact us ASAP.
- Cancellations must be 48+ hours in advance to avoid a cancellation fee.
- The fee for cancellations under 48 hours is half the appointment price.
- The fee for cancellations under 24 hours is the full appointment price.
- The fee for no-shows and late arrivals by 15 minutes or more is the full appointment price.
- Three missed appointments in a row results in a discharge from care.
- Email reminders are in no way guaranteed, and they do not affect the cancellation policy in any way.
- If I do not read my appointment reminder correctly, or if my device causes a skewed representation of my appointment time via email reminder, I know that I am nonetheless responsible for my appointment time as it is scheduled in Dr. Rozenn's appointment software. I know that I am subject to cancellation fees if I miss my appointment for this reason. I know that email reminders are a courtesy only and relying on email reminders is an inappropriate way to keep track of my appointments.

_____

Printed Name Date

_____

Signature

Maureen Rozenn, LAC, DAOM, FABORM
Doctor of Acupuncture and Oriental Medicine
845 Cedar Street, Santa Cruz, CA 95060
Phone: 831.426.1093 Fax: 831.426.6523

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Directions

From Highway 17 or 1 North

From highway 17 or 1 North, exit into Santa Cruz towards 1 North to Half Moon Bay.
Go straight through the first light at River St. and Highway 9.
Go straight through the second light at the cross between Mission, Highway 1 and Chestnut.
Going straight through this light will put you on Chestnut Street.
Continue down Chestnut and make a left on Walnut.
The parking lot for Plaza de la Cruz is on Walnut Street, just before it intersects with Cedar Street.
The Clinic is on the Cedar Street side of Plaza de la Cruz.

Be sure to park in one of several spaces labeled, "Customers." If the lot is full, there is metered street parking and a pa lot directly across Cedar Street from the clinic.

From North of Santa Cruz

If coming from North of Santa Cruz, follow 1 South into Santa Cruz.
It will become Mission Street.
Go right on Chestnut.
Go left on Walnut.

The parking lot for Plaza de la Cruz is on Walnut Street, just before it intersects with Cedar Street.
The Clinic is on the Cedar Street side of Plaza de la Cruz.

Be sure to park in one of several spaces labeled, "Customers." If the lot is full, there is metered street parking and a pa lot directly across Cedar Street from the clinic.

Hello, and welcome to my practice!

Congratulations on taking the first step to better health! As a Doctor of Acupuncture and Oriental medicine, I practice Integrative medicine. My tools include acupuncture, herbal therapy, diet and lifestyle counseling, and nutritional supplements. I utilize Western lab reports when appropriate, as well as traditional Oriental diagnostics, to guide your treatment and help you reach your personal health goals.

During our first meeting we will go over your health history. So, along with the enclosed paperwork, bring any herbs/supplements/drugs you are currently taking to your first appointment. Be sure to bring any pertinent lab work and imaging reports.

In accordance with ancient teaching methods of Oriental medicine's tradition, Endless Possibilities Acupuncture, Inc. is an education-focused practice. Chinese medicine students, known as interns, assist me daily with various clinic duties. This includes observing patient visits, taking chart notes, and preparing patient materials based on my instructions during your appointment. If for any reason you do not wish to have a student observing your visit, please let me know, as your comfort is most important.

Please allow 2 hours for your initial visit. Women's Fertility Visits are $250.00 and last approximately 2.5 hours. Follow up visits, which include an office visit and acupuncture, are $135.00 and last between 60-75 minutes. These estimates include time for parking, checking out, etc. While I do not bill insurance directly, you may request an insurance receipt when checking out at the end of your visit. If you have any questions about this, please ask my assistant at the front desk. If you need to cancel or reschedule, please notify us at least 48 hours in advance by phone or email to avoid a late-cancellation fee.

My schedule tends to book out in advance, with most appointment openings falling about six weeks from the current date. If you need your planner to book ahead, please bring it. If you can't get in on the appointment date you need, do not worry! We have a very effective cancellation list, and my associate Katie Tobiska, LAC, is also available for appointments. For more information about Katie, visit our website, listed below.Ultimately, Chinese medicine is most profound when treated as a partnership between doctor and patient. If we work together, you will learn more than you ever dreamed about your body, including how to maintain the balance we achieve in the clinic... in your own life, on you terms.

For more information about me and my practice, visit my website www.AcupunctureSantaCruz.net. You can contact my office at office@AcupunctureSantaCruz.net. I look forward to your visit!

Sincerely,

Dr. Maureen Rozenn, LAC, DAOM, FABORM