Welcome to Po-Lin Acupuncture Clinic

1426 Fillmore Street, Suite 202
San Francisco, CA 94115
415-752-5638

Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. Po-Lin Acupuncture Clinic considers this information privileged physician/patient communication and will hold it in confidence.

Patient Information

NAME (LAST, FIRST, MIDDLE)					DATE
AGE	DATE OF BIRTH	SEX __ Male __ Female	MARITAL STATUS _ Single _ Married _ Separated _ Divorced _ Widowed		
HOME ADDRESS			CITY	STATE	ZIP
PHONE – CELL			EMAIL ADDRESS		
EMPLOYED BY					
EMPLOYERS ADDRESS			CITY	STATE	
OCCUPATION			WORK PHONE		
SPOUSE'S NAME					
CONTACT IN CASE OF AN EMERGENCY			RELATIONSHIP	PHONE	
MEDICAL INSURANCE CARRIER			POLICY NUMBER	GROUP NUMBER	
HOW DID YOU HEAR ABOUT OUR CLINIC?					
NAME OF YOUR OB-GYN DOCTOR		NAME OF YOUR FERTILITY OR REPRODUCTIVE CLINIC			

CONFIDENTIAL

NAME (LAST, FIRST, MIDDLE)	DATE

Medical History

MAJOR COMPLAINT/HEALTH PROBLEM YOU WOULD LIKE US TO TREAT:

_____
_____
_____
_____
_____

HOW DID THIS CONDITION DEVELOP?

_____
_____
_____
_____

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC.)

_____
_____
_____

HOW LONG HAS THIS CONDITION PERSISTED?

_____
_____
_____

IS THERE ANYTHING THAT MAKES IT BETTER OR WORSE?

_____
_____

IF YOU HAVE PAIN—IS IT SHARP OR SHOOTING, PINS AND NEEDLES, OR DULL? CHRONIC OR ACUTE?

_____
_____
_____

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NAME (LAST, FIRST, MIDDLE)	DATE

LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO:

_____

_____

_____

_____

LIST ANY MEDICATIONS/HERBS/DRUGS THAT YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____

LIST ANY MAJOR SURGERIES YOU HAVE HAD:

_____

_____

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

AIDS	Yes	No	High Blood Pressure	Yes	No
Anxiety Attacks	Yes	No	Intestinal Bleeding	Yes	No
Asthma	Yes	No	Kidney Infection	Yes	No
Autoimmune Disease	Yes	No	Kidney Stones	Yes	No
Birth Defects	Yes	No	Lupus Erythematosis	Yes	No
Bladder Infections	Yes	No	Migraine	Yes	No
Blood Disorders	Yes	No	Neurologic Disorders	Yes	No
Breast Tumors or Cancer	Yes	No	Other Forms of Arthritis	Yes	No
Bronchitis	Yes	No	Other Heart Conditions	Yes	No
Cancer	Yes	No	Other Kidney Problems	Yes	No
Cirrhosis	Yes	No	Other Lung Problems	Yes	No
Connective Tissue Disorders	Yes	No	Panic Attacks	Yes	No
Diabetes	Yes	No	Paralysis	Yes	No
Epilepsy	Yes	No	Pneumonia	Yes	No
Gallstones	Yes	No	Prolonged Dizziness	Yes	No
Gastric/Duodenal Ulcers	Yes	No	Rheumatic Fever	Yes	No
German Measles (Rubella)	Yes	No	Rheumatoid Arthritis	Yes	No
Glasses/Contact lenses	Yes	No	Seizures	Yes	No
Heart Attack	Yes	No	Thyroid Problems	Yes	No
Heart Disease	Yes	No	Tuberculosis	Yes	No
Heart Murmur	Yes	No	Varicose Veins	Yes	No
Hepatitis	Yes	No			

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NAME (LAST, FIRST, MIDDLE)	DATE

Health History

Please check any symptoms you currently have or have had in the past year:

General
- ❑ Chills
- ❑ Low energy
- ❑ Dizziness
- ❑ Allergies
- ❑ Fatigue
- ❑ Fevers
- ❑ Excess thirst
- ❑ Insomnia
- ❑ Nervousness
- ❑ Numbness
- ❑ Sweat spontaneously
- ❑ Night sweating
- ❑ Lack of sweating
- ❑ Weight loss
- ❑ Weight gain
- ❑ Aversion to heat
- ❑ Aversion to cold

Head & Neck
- ❑ Blurred vision
- ❑ Heaviness in the head
- ❑ Headache
- ❑ Phlegm in throat
- ❑ Cataract
- ❑ Double vision
- ❑ Earache
- ❑ Ear discharge
- ❑ Eye pain/strain
- ❑ Corrected vision
- ❑ Nasal obstruction
- ❑ Nasal discharge
- ❑ Loss of sense of smell
- ❑ Hearing loss
- ❑ Hoarseness
- ❑ Nosebleeds
- ❑ Recurrent sore throat
- ❑ Red/inflamed eye
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Sores on lips
- ❑ Sores on tongue
- ❑ Taste change
- ❑ Teeth problems
- ❑ Vision – see halos

Respiratory
- ❑ Asthma
- ❑ Hay fever
- ❑ Persistent cough
- ❑ Coughing blood
- ❑ Shortness of breath
- ❑ Recurrent bronchitis
- ❑ Phlegm production
- ❑ Difficulty inhaling
- ❑ Difficulty exhaling

Cardiovascular
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Irregular heartbeat
- ❑ Poor circulation
- ❑ Swelling of ankles
- ❑ Varicose veins
- ❑ Hypochondriac pain
- ❑ Distention in chest or hypochondrium

Gastrointestinal
- ❑ Abdominal pain
- ❑ Bloating
- ❑ Belching
- ❑ Gas
- ❑ Constipation
- ❑ Diarrhea/loose stools
- ❑ Bloody stools
- ❑ Black stools
- ❑ Difficulty swallowing
- ❑ Poor appetite
- ❑ Heartburn/reflux
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Poor appetite
- ❑ Stomachache
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood

Diet/Lifestyle
- ❑ Vegetarian
- ❑ Healthy diet
- ❑ Eat much fried foods
- ❑ Eat much meat
- ❑ Smoke cigarettes
- ❑ Drink alcohol
- ❑ Drink coffee
- ❑ Use drugs
- ❑ Eat many sweets
- ❑ Take melatonin
- ❑ Take steroids
- ❑ Exercise regularly
- ❑ Exercise excessively

Weight
- ❑ Underweight
- ❑ Normal for height
- ❑ Overweight
- ❑ Very overweight

Genitourinary
- ❑ Dilute urine
- ❑ Dark urine
- ❑ Blood in urine
- ❑ Cloudy urine
- ❑ Burning urination
- ❑ Scanty urine
- ❑ Profuse urine
- ❑ Frequent urination
- ❑ Poor bladder control
- ❑ Urgency to urinate

Musculoskeletal

Pain, weakness, numbness:
- ❑ Arms
- ❑ Feet
- ❑ Hands
- ❑ Joints
- ❑ Legs
- ❑ Hips
- ❑ Neck
- ❑ Shoulders
- ❑ Pain all over
- ❑ Cold limbs
- ❑ Knee problems
- ❑ Low back pain
- ❑ All over weakness
- ❑ Lack of strength
- ❑ Broken bones

Skin
- ❑ Thick skin
- ❑ Thin skin
- ❑ Broken blood vessels
- ❑ Blood not clotting
- ❑ Bruise easily
- ❑ Discoloration
- ❑ Dark circles around eyes
- ❑ Bags under eyes
- ❑ Lumps in groin
- ❑ Lumps underarm
- ❑ Dry skin
- ❑ Acne
- ❑ Brittle nails
- ❑ Premature gray hair
- ❑ Dry, brittle hair
- ❑ Hair falling out

Neurologic
- ❑ Fainting
- ❑ Convulsions
- ❑ Handwriting change
- ❑ Paralysis
- ❑ Stroke
- ❑ Seizures
- ❑ Tremor
- ❑ Recent clumsiness
- ❑ Drowsiness
- ❑ Vertigo

Emotional
- ❑ Insomnia
- ❑ Irritability
- ❑ Often feel angry
- ❑ Troubling dreams
- ❑ Cry uncontrollably
- ❑ Feel sad a lot
- ❑ Forgetful
- ❑ Mind not clear
- ❑ Anxiety
- ❑ Much fear
- ❑ Unrestrained joy
- ❑ Terrors
- ❑ Difficulty expressing emotions

Men Only
- ❑ Genital pain
- ❑ Impotence
- ❑ Genital sores
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Nocturnal emission
- ❑ Low sexual energy

Women Only
- ❑ Abnormal pap smear
- ❑ Bleed between periods
- ❑ Irregular periods
- ❑ Heavy periods
- ❑ <25 day cycle
- ❑ >35 day cycle
- ❑ Endometriosis
- ❑ Painful periods
- ❑ Premenstrual tension
- ❑ Breast lumps
- ❑ Contraceptives
- ❑ Sores on genitalia
- ❑ Low sexual energy
- ❑ Vaginal discharges
- ❑ Menopausal
- ❑ Uterine prolapse
- ❑ Facial hair
- ❑ Loss of head hair
- ❑ May be pregnant

CONFIDENTIAL

NAME (LAST, FIRST, MIDDLE)	DATE

Age at which menses began _____

Date of last menstrual period_____

Are your periods painful? __Yes __ No __ Somewhat How many days does the pain last? _____

Are your menstrual cycles spaced irregularly? __ Yes __ No

How many days are there from one period to the next? _____

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 Size_____ Color_____

Do you bleed or spot between periods? __ Yes __ No

Do your bowel movements become loose at the beginning of your period or just before? __Yes __No

Do you have premenstrual tension? __ Yes __ No

Do your breasts become tender premenstrually? __ Yes __ No

Do you get premenstrual low back pain? _ Yes _ No

Does your face break out before or during your period? __ Yes __ No

	Number	Years
How many pregnancies have you had?	_____	_____
How many children do you have?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____
How many times has a D&C been performed?	_____	_____

Date of last Pap smear_____

Have you ever had an abnormal pap smear? __ Yes __ No

Have you ever had a cervical biopsy, operation, cauterization, or conization? __ Yes __ No

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Have you ever had a venereal disease? (Chlamydia, gonorrhea, syphilis, herpes, other)__ Yes __ No

Have you ever had pelvic inflammatory disease? __ Yes __ No
Were you treated for it? __ Yes __ No
How_____

Do you get yeast infections regularly? __ Yes __ No How do you treat them?
_____

Do you have chronic vaginal discharge? __ Yes __ No

Do you have any sores on your genitalia? __ Yes __ No

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 been diagnosed with any pelvic abnormalities? __ Yes __ No

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Have you taken any medications for gynecological conditions other than contraceptives? __ Yes __ No

Medication	**Reason**	**How long**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since they began? __ Yes __ No
How? _____

Do you ovulate on your own? __ Yes __ No
On what day of your cycle?_____

Have you taken medication to help you ovulate? __Yes __No
When _____ How long?_____

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Do you get stretchy cervical mucus around ovulation? __ Yes __ No

Do your breasts get tender at/during ovulation? __ Yes __ No

Do you use a BBT graph to chart your temperature rise and ovulation? __ Yes __ No

Have you had fertility treatments? __ Yes __ No
If yes, when and where?_____
By whom?_____
What types?_____

Do you know what your FSH level is on Day 3? __Yes __No
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? _____

Has your partner or spouse had a fertility workup? __ Yes __ No
What were the results?_____

Is your partner supportive of your wish to conceive? __ Yes __ No

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

Do you douche regularly? __ Yes __ No
With what?_____

Do you use vaginal lubricants? __ Yes __ No

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

Do you have excessive facial hair? __ Yes __ No

Do you have excessively oily skin? __ Yes __ No

Have you experienced excessive loss of head hair? __ Yes __ No

Have you noticed any discharge from your nipples? __ Yes __ No

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NAME (LAST, FIRST, MIDDLE)	DATE

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

Any irregular lab results for the thyroid? __ Yes __ No

Do you have natural killer cells? __ Yes __ No

Have you done LIT or IVIG? __ Yes __ No When? _____

Have you taken oral contraceptives? __ Yes __ No
When _____ How long?_____

Have you ever had an IUD? __ Yes __ No
When _____ How long?_____

Have you ever taken Depo Provera? __Yes __No
When _____ How long?_____

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? __ Yes __ No
What was it?_____

Are you planning to do?

IUI_____ IVF_____ OTHER _____

Estimated date of procedure _____

What drugs/medications will you be taking in preparation for this procedure and when do you start?
_____
_____
_____
_____

CONFIDENTIAL

NAME (LAST, FIRST, MIDDLE)	DATE

Male Fertility History

Do you have undescended testes? ..... Yes No

Have you ever been diagnosed with a varicocele? ..... Yes No

Have you had any urologic surgeries? ..... Yes No

Have you experienced difficulty maintaining an erection?..... Yes No

Have you experienced difficulty ejaculating?..... Yes No

Have you had exposure to any known environmental toxins or hormones? ..... Yes No

Have you experienced any penile discharge? ..... Yes No

Do you regularly experience nocturnal emission?..... Yes No

Have you had a fertility workup?..... Yes No

If yes, what was your sperm count? __ Below normal __Normal Number_____

What was the sperm motility? __ Below normal __ Normal Number _____

What was the sperm morphology? __ Abnormal __ Normal Number _____

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CONSENT FOR ACUPUNCTURE TREATMENT

I hereby request and consent to acupuncture treatments and other procedures within the scope of the practice of acupuncture on me by the acupuncturist named below.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxa, massage, cupping, electrical stimulation, 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. I will immediately notify my acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that It may have some side effects including bruising and/or numbness or tingling near the needling sites that may last a few days.

There have been rare instances reported in which a patient fainted, developed a scar or infections, experienced a spontaneous abortion, or sustained a pneumothorax (air in the chest cavity that could cause a collapsed lung). The herbs and nutritional supplements that have been recommended are considered safe in the practice of Chinese medicine. Some herbs may have undesirable effects in larger doses than we recommend. Some possible side effects of taking herbs are nausea, gas, stomachache, diarrhea, or rashes. I will notify my acupuncturist if I am pregnant since some herbs can be harmful.

I do not expect my acupuncturist to be able to anticipate and explain all possible risks and complications of treatments. I wish to rely on my acupuncturist to exercise sound judgment during the course of treatment. I understand that results are not guaranteed.

By voluntarily signing below, I show 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 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 Signature: _____ Date: _____

Acupuncturist Signature: _____ Date: _____

Polin Acupuncture financial policy

I understand that health insurance policies are an arrangement between an insurance carrier and myself. I assume full responsibility for verification of benefits, including which services are covered under my policy, the portion of fees covered, and annual maximum of coverage. Furthermore, I understand that Polin Acupuncture will prepare any necessary reports and claim forms to assist me in collecting reimbursement from my insurance company and that I will collect the amount covered directly from my insurance company. Any amount paid to the provider will be reimbursed to the patient by check upon receipt. I clearly understand that all services rendered are charged directly to me and that I am personally responsible for payment in full at the time of service.

Your appointment time is reserved specifically for you. Therefore, Polin Acupuncture requests at least 24 hours notice for any cancellation or rescheduling of appointment times. Repeat missed appointments, or short notice cancellations may result in a missed appointment fee of $45.00. Exceptions to this policy include cancellations due to illness, family or personal emergency, and last-minute changes in the scheduling of procedures with your medical doctor. Please notify Polin Acupuncture as soon as possible if you are unable to keep your appointment for any of these reasons.

Polin Acupuncture fee schedule:

Initial Visit with treatment $140.00
Acupuncture $95.00
Reproductive Organ Massage 50 minutes $95.00
Prepay package-11 treatments $950.00
Prepay packages do not expire.
Herb and supplement prices are variable according to medication prescribed and amount of medication prescribed

Please sign and date below stating that you have received and understand the above policies

Name: _____Date: _____