Fertility Coaching Intake Form

Welcome to THE POINT. We are committed to providing you the best medical care possible.
Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully.

Name_____ Date _____
Age_____ Date of Birth_____ Occupation_____
Address_____ Home phone_____
City State Zip _____ Cell phone_____
Email_____ Work phone_____
How did you hear about us? _____ Your preferred phone # Home Work Cell
□ Friend □ Ad □ Website □Doctor □ Other _____ May we leave a message? Y N

What is your main reason and/or goal for this appointment?_____
_____

How long have you been trying to get pregnant?_____

How long have you been doing the Becoming Mama Protocol?_____

Which Fertility Pattern do you think you are?_____

Have you been diagnosed with any of the following:

- □ PCOS
- □ Luteal phase defect
- □ Low AMH
- □ High FSH
- □ Low progesterone
- □ Ovarian Cyst
- □ Fibroid
- □ Migraine headaches
- □ Autoimmune Disease
- □ Cancer
- □ Epilepsy
- □ Bleeding Disorder
- □ High Cholesterol
- □ Heart Disease
- □ Stroke
- □ Thyroid Disorder
- □ Infertility
- □ Chronic Fatigue Syndrome
- □ Hypertension
- □ Osteopenia/Osteoporosis
- □ Diabetes
- □ Depression
- □ Anxiety
- □ AIDS/HIV

Please indicate if you have or are taking any of the following:

- □ Pacemaker
- □ Sleeping Aids
- □ Cortisone or other Steroids
- □ Antacids (Tums, etc.)
- □ Clotting Disorder
- □ Blood Thinners (Warfarin, Coumadin, etc)
- □ Diet Pills (diuretics, appetite suppressants, etc.)
- □ Pain Relievers (Tylenol, Aspirin, etc.)
- □ Contagious Disease
- □ Thyroid medication
- □ Laxatives
- □ Tranquilizers/Sedatives

Please list any hospitalizations and/or surgeries/injuries/accidents:

Hospitalization/Surgery/Accident/Injury	Date	Reason / Relation to health concerns

Please list all prescription and over-the-counter medications you are currently taking:

Name	Dosage	Reason for taking	Date began taking

Please list all vitamins, supplements, herbs, performance enhancing aids and/or weight loss products:

Name	Dosage	Reason for taking	Date began taking

Approximately how many courses of antibiotics have you taken in the past 10 years?_____

Allergies (drug, chemical, food, seasonal):_____
_____

Family Health History (Parents and Siblings)

- □ Arthritis
- □ Asthma
- □ Alcoholism
- □ Alzheimer's disease
- □ Cancer
- □ Depression
- □ Diabetes
- □ Drug Addiction
- □ Eating Disorder
- □ Genetic Disorder
- □ High Blood Pressure
- □ Heart Disease
- □ Infertility
- □ Learning Disabilities
- □ Mental Illness
- □ Migraine headaches
- □ Parkinson's
- □ Obesity
- □ Osteoporosis
- □ Stroke
- □ Suicide

Survey of Symptoms: Please check current symptoms (** the ones that occur frequently, and write "past" next to those conditions which you have only had in the past and are no longer present).

Head & Neck:
□ Dizziness
□ Floaters
□ Blurry vision
□ Neck Stiffness
□ Enlarged lymph glands
□ Headaches
□ Migraines
□ TMJ

Ears:
□ Infection
□ Ringing
□ Decreased hearing

Nose, Throat, & Mouth:
□ Nose bleeds
□ Nasal congestion
□ Sinus infection
□ Hay fever/ allergies
□ Sore throat
□ Hoarseness
□ Mouth sores
□ Dry mouth

Skin:
□ Hives / Rashes
□ Eczema
□ Psoriasis
□ Acne
□ Night sweating
□ Excess sweating
□ Dry skin
□ Bruise easily

Respiratory:
□ Chronic cough
□ Coughing up blood
□ Coughing up phlegm
□ Difficulty breathing
□ Asthma/Wheezing
□ Catch cold easily
□ Emphysema
□ Pneumonia

Gastrointestinal:
□ Indigestion
□ Nausea
□ Vomit
□ Bloating
□ Gas
□ Heartburn
□ Distention of abdomen
□ Stomach pain
□ Irritable Bowel
□ Colitis
□ Crohn's Disease
□ Celiac Disease
□ Ulcer
□ Bad Breath
□ Diarrhea
□ Constipation
□ Dry, hard stools
□ Soft, sticky stools
□ Blood in stools/black stools
□ Hemorrhoids
□ Poor appetite
□ Excessive hunger
□ Excessive thirst
□ Gall Bladder problems/stones
□ Recent weight change
□ Food cravings
□ Hypoglycemia

Urinary:
□ Frequent day urination
□ Frequent night urination
□ UTI/bladder infection
□ Weak urine stream/dribbling
□ Kidney disease
□ Recent change in bladder habits

Muscle & Joints:
□ Arthritis
□ Joint stiffness
□ Sore muscles
□ Weak muscles
□ Back pain
□ Sciatica
□ Fibromyalgia

Cardiovascular:
□ Palpitations
□ Chest pain or tightness
□ Rapid heart beat
□ Irregular heart beat
□ Heart disease
□ Poor circulation
□ Cold hands/feet
□ Swelling ankles
□ High blood pressure
□ Stroke
□ Anemia

Infection:
□ HIV/AIDS
□ TB
□ Hepatitis
□ STD
□ Herpes

Neurological:
□ Numbness or tingling
□ Seizures / Convulsions
□ Tremors
□ Paralysis

General:
□ Fatigue
□ Thirst
□ Chills/aversion to cold
□ Insomnia
□ Depression
□ Agitation/Anxiety
□ Irritability
□ Poor memory
□ Difficulty concentrating
□ Jaundice
□ Gout
□ Hernia
□ Diabetes Mellitus
□ Thyroid disorder
□ Cancer
□ Alcoholism
□ Lowered libido
□ Other _____

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Reproductive Health:

Pregnancies _____ # Children _____ # Miscarriages _____

Date of last period _____ Is your cycle regular? Y N Day of cycle you ovulate _____

# of days of flow_____ # of days from start of one period to the next: _____

Bleeding: □light □normal □heavy □watery □ clots

Color of blood: □light red □red □dark red □purple □brown □black

□ Spot a few days before your period comes □ Bleeding between periods Is your cycle painful? □ Yes □ No
Nature of pains (indicate which days of your cycle or before your cycle the pain occurs)
Cramping_____ Stabbing_____ Burning_____ Aching_____ Dull_____
Intermittent_____ Consistent_____ Down-bearing_____ Better with hot -pad_____

PMS symptoms:
□ Breasts get tender or swollen before period: how many days before?_____
□ Bloating before your period □ Fatigue □ Irritability □ Melancholy □ Headaches □ Loose stools
□ Increased appetite □ Decreased appetite □ Insomnia

Other symptoms:
□ Hot flashes □ Night Sweats □ Vaginal Dryness □ Frequent yeast infections □ Frequent UTIs

Please indicate whether you have been diagnosed with any of the following:
□Fibroids □Fibrocystic Breasts □Ovarian Cysts □Endometriosis □PCOS □Other_____

Is there anything else you would like us to know?_____
_____
_____

Thank you for taking the time to answer these questions, we appreciate your time and effort.
I certify that the information I have provided above is correct and accurate to the best of my knowledge.

_____ _____ _____
Patient's (or Patient Representative's) Signature *Patient's Name* *Date*

_____ _____
Patient Representative's Name *Representative's relationship to patient*

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COLORADO MANDATORY DISCLOSURE STATEMENT

THE POINT
1705 South Pearl Street #4
Denver, CO 80210
720.523.3351

Please read the following and sign below after you have had any questions answered and have understood this statement to your satisfaction.

Fee Schedule
Payment is due at the time of service. If your insurance does not cover this service, there is a time of service discount applied. The current discounted rates are:

Fertility Coaching e-visit	$75 for a half hour
Acupuncture	
Initial Visit	$95 + cost of herbs
Follow-up Visit	$75 + cost of herbs

Any services offered by an employee at The Point Acupuncture & Holistic Medicine, LLC are not intended to substitute for those offered by a licensed medical doctor when needed. Referrals are made for further workup and treatment when appropriate. Patients may seek a second opinion from other health care practitioners or terminate therapy at any time. The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202; (303) 894-7800.

I have read and understand this document, have had an opportunity to have any and all questions answered on the subject, and freely seek the services offered.

_____ _____

Patient's or Guardian's Signature *Date*

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use your health information for treatment or disclose it to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the Federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include: quality assessment and improvement activities, reviewing competence of healthcare professionals, evaluation practitioner/provider relationships, conducting training programs, accreditation, certification, and credentialing or licensing activities. We may also disclose your information to another healthcare provider or organization that is subject to the Federal Privacy Rules and that has a relationship with you to support some of their health care operations.

On Your Authorization: You may give us written authorization to use your health care information or disclose it to anyone for any purpose. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your health care or with payment for your health care. Before we disclose your health information, we will provide you with an opportunity to object to our use or disclosure. If you are not present or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We will also use our experience and professional judgment to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, or similar forms of health information.

Courtesy Calls & Appointment Reminders: We may use or disclose your health information to provide you with appointments reminders, courtesy calls, etc. via voicemail, email, postcards, and letters.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law
- For public health activities (disease/statistic & child abuse reporting, work-related illness or injury)
- To report abuse, neglect, or domestic violence
- In response to court and administrative orders and other lawful processes

YOUR RIGHTS - You Have The Right To:

- Request a copy of our Privacy Practices Notice at any time
- Look at and obtain a copy of your health information
- Deny courtesy calls, emails, or letters sent by our office
- Request a restriction on certain uses and disclosures of your health care information
- Receive confidential communications regarding your health information
- Revoke authorizations that you made previously in regards to your protected health information

OUR RESPONSIBILITIES - We Have The Right To:

- Maintain the privacy of your health information as required by federal and state law
- Provide you with a notice of our Duties and Privacy Practices
- Abide by the terms of this notice

HIPAA - Acknowledgment of Notice of Privacy Practices and Consent to Treat

With my consent, THE POINT may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to THE POINT's **Notice of Privacy Practices** for more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

With my consent, THE POINT may call my home or any other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, THE POINT may mail to my home or other designated location any items that assist the practice carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked as personal and confidential.

With my consent, THE POINT may email me appointment reminders and patient's statements. I have the right to request that THE POINT restrict how it uses or discloses my PHI to carry out TPO.

By signing this form, I am consenting to THE POINT's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, THE POINT may decline to provide treatment to me.

I, _____, hereby acknowledge that I read and reviewed a copy of THE POINT's Notice of Privacy Practices and fully understand this consent form. I am consenting to the use and/or disclosure of my health information to treat me and arrange for my medical care. I am consenting to be treated.

_____ _____

Signature of Patient or Parent/Legal Guardian *Date*

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