Fertile Ground Wellness Center
1091 S. Gaylord St.
Denver, CO 80209

Office: (303)248-3481
Fax: (720) 836-4174
fertilegroundwellnesscenter@gmail.com

General Health Intake Form

Name _____ Date of birth ____/____/____ Age _____

Street Address _____

City _____ State _____ Zip _____

Phone _____ Alternate Phone _____

Email address _____

❒ Yes, I would like to be added to the Fertile Ground email list

Employer _____ Phone _____

Occupation _____

Marital Status _____ Number of Children _____

Personal Physician _____ Phone _____

Emergency Contact _____ Phone _____

Who can we thank for referring you to our office? _____

Clinic Policy

Your appointment time has been specifically reserved for you. If you need to cancel an appointment, we ask that you give 24 hours notice. If less than 24 hours notice is given for a cancelled appointment or an appointment is missed, we reserve the right to bill you for the full amount of the appointment.

Payment for services will be due at the time of the visit. Cash, checks, and credit cards are acceptable forms of payment. Credit cards are processed through Therapy Partner. Upon your request, an invoice with procedure codes and diagnosis codes can be printed for you to submit to your insurance company. However, Fertile Ground cannot be responsible for the insurance company's failure to reimburse.

Signature

Please indicate your understanding and acceptance of these policies by signing below:

Signed _____ Date _____

HIPPA Form

Please check and initial the following to indicate you have read and understand the information in these forms and accept the policies therein: *Initials*

❒ HIPPA Form & Protecting Your Health Information _____

Acupuncture Informed Consent

I hereby request and consent to the performance of acupuncture and/or Chinese herbal treatments and other procedures within the scope of acupuncture on me (or the patient named below, for whom I am legally responsible) by the acupuncturist, named below and or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as a back-up for the acupuncturist named below.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Public Health and Environment, including the use of single-use, sterile needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are used in this clinic. There are some risks to treatment including but not limited to some bruising of the skin and/or slight bleeding.

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 Licensure Office, 1560 Broadway, Suite 1340, Denver, CO 80202. Telephone (303) 894-7851.

I have had an opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture. I understand that the results are not guaranteed.

Patient Rights

- The patient is entitled to receive information about methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- 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.

I have read, or have had read to me, the above consent and have had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend for 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: _____

Practitioner Signature: _____ Date: _____

Cecily Yousaf, MSOM, L.Ac.
Licensed Acupuncturist and Owner of Fertile Ground

Acupuncture Fee Schedule

Adults	*Couples*	*Lactation*	*Pediatrics*
New patient: $120.00	$120.00	New patient: $70.00	Infant-3 years: $60.00
Return visit: $70.00		Return visit: $60.00	

The first office visit is 1-1.5 hours in length, return office visits are generally 1 hour in length.

Signature

Please indicate your understanding and acceptance of the acupuncture fee schedule:

Signed _____ Date _____

Acupuncture Disclosure Form

Please check and initial the following to indicate you have read and understand the information in the Acupuncture Disclosure Form and accept the policies therein: *Initials*

❒ Acupuncture Disclosure Form _____

General Information	YES	NO
Have you ever had acupuncture before?	❑	❑
Are you now or could you be pregnant? Date of conception_____	❑	❑
Do you have a history of miscarriage?	❑	❑
Do you have a pacemaker, heart arrhythmia, or other heart condition?	❑	❑
Have you ever had blood-clotting problems or problems with bleeding?	❑	❑
Are you on blood thinning medications?	❑	❑
Do you take aspirin regularly?	❑	❑
Have you ever been diagnosed with Hepatitis?	❑	❑
HIV?	❑	❑
AIDS?	❑	❑
TB?	❑	❑

If so, when?_____

Prescription Medications
Please list any prescription medications you are currently taking and what they are for:

Vitamins/Supplements
Please list any vitamins or other supplements you are taking:

Surgical History
Please list all surgeries and approximate age:

Major Accidents/Injuries
Please list any major accidents (include head injuries, fractures, deep cuts, serious sprains, etc.) Indicate date or age:

Primary Complaint
Please include: description of complaint, location, date and/or time of onset, cause (if known), frequency of problem, factors aggravating symptoms, factors alleviating symptoms, etc.

	YES	NO
Have you ever had this condition or one like it before?	❑	❑
Have you ever been treated for this condition before?	❑	❑

When?_____ By whom? _____

Has your condition improved, stayed the same or gotten worse?_____

Is there pain associated with this condition? ❑ ❑

Please describe the pain (stabbing, burning, stitching, drawing, boring, dull ache, fixed,

wandering, colicky, spasmodic, distending, etc.)_____

Is your pain affected by applying heat or cold? _____

Is the pain better with rest or activity? _____

Is the problem affected by climate, weather changes, etc. ❑ ❑

If so, what type of weather aggravates it? _____

What are the possible emotional or stress factors related to the condition/problem?

Is there a time of day or night when the condition/problem is worse?

Are there any other symptoms that manifest with the Primary Complaint?

Secondary Complaints:

General Condition
Please check any of the following that *presently* apply to you:

Energy Levels

- ❑ Are you fatigued or do you fatigue easily
- ❑ Do you need to take naps
- ❑ Do you generally feel cold
- ❑ Do you have cold feet and/or hands
- ❑ Do you catch colds frequently
- ❑ Do you have energy slumps at certain times of day
- ❑ Do you wake up tired in the morning
- ❑ Do you feel energized after exercise
- ❑ Do you regularly have a low-grade fever
- ❑ Does your sweat have a strong odor
- ❑ Do you ever wake up sweating at night
- ❑ Do you perspire easily without exertion
- ❑ Do you feel tired after meals
- ❑ Do you have excess/nervous energy
- ❑ Does your energy pick up after you get up and move about in the morning

Appetite and Digestion

- ❑ Has your appetite changed lately
- ❑ Do you have a poor appetite
- ❑ Are you hungry all/most of the time
- ❑ Do you feel foggy or low if you miss a meal
- ❑ Do you have abdominal (intestinal) bloating
- ❑ Do you experience belching/hiccups
- ❑ Do you have heartburn
- ❑ Do you have gurgling sounds in your intestines
- ❑ Do you have a nervous stomach
- ❑ Do you have intestinal gas
- ❑ Do you experience a bitter taste
- ❑ Do you have acid regurgitation
- ❑ Do you crave particular foods
  - ❑ Sweet ❑ Salty
  - ❑ Bitter ❑ Sour
  - ❑ Hot or spicy
- ❑ Do you experience bad breath

Nutrition/Diet Information

Please describe your appetite

❒ Strong ❒ Normal ❒ Poor

Do you hunger quickly? ❒ Yes ❒ No

Please describe your diet (low fat, low-carb, vegetarian, etc.)

Please list what you ate yesterday

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

If you eat any of the following, please check and list how much per week

- ❒ Candy _____
- ❒ Cookies/Bake goods _____
- ❒ Chocolate _____
- ❒ White flour bread _____
- ❒ Soda-Regular/Diet _____
- ❒ Milk-skim/2%/whole _____
- ❒ Caffeine _____
- ❒ Cheese _____
- ❒ Fast food _____
- ❒ Protein _____
- ❒ Vegetables-dark green _____
- ❒ Fruit _____
- ❒ Alcohol _____

Dryness

How much water do you drink each day? _____

Other fluids _____

Do you prefer your drinks: ❑ cold ❑ warm/hot ❑ room temperature

Please describe your thirst

❒ Strong ❒ Normal ❒ Poor

- ❑ Do you have dry eyes
- ❑ Do you have a dry nose
- ❑ Do your mouth and lips tend to be dry
- ❑ Do you have dry hair
- ❑ Do you have dry skin
- ❑ Do you have frequent nosebleeds

Stools & Urine

Do you have or experience:

- ❑ Bowel movements less than 5x/week
- ❑ Bowel movements more than 2x/day
- ❑ Blood or pus in your stools
- ❑ Stools unusually light/dark in color
- ❑ Any undigested food in your stool
- ❑ Constipation
- ❑ Diarrhea
- ❑ Alternating constipation and diarrhea
- ❑ Hemorrhoids
- ❑ Excessive gas
- ❑ A feeling of being unfinished after the stool is discharged
- ❑ Abdominal discomfort that is relieved after passing the stool
- ❑ Wake at night to urinate
- ❑ Dribbling urine
- ❑ An urgency to urinate
- ❒ Urine with a strong odor
- ❑ Burning with urination
- ❑ Incontinence
- ❑ Cloudy urine
- ❑ Blood in your urine
- ❑ Abdominal pain/cramps

Sleep

- ❑ Are you easily startled
- ❑ Do you dream excessively
- ❑ Do you wake early and have trouble getting back to sleep
- ❑ Do you experience insomnia
  - ❑ If so, do you wake at the same time most nights? What time? _____
- ❑ Do you have restless/fitful sleep
- ❑ Do you have trouble getting to sleep

Emotional/Cognitive

- ❑ Do you experience an emotion/pattern often or excessively

  If so, which emotions/patterns?

  - ❑ Anger ❑ Fear ❑ Worry ❑ Sadness/Grief
  - ❑ Joy ❑ Depression ❑ Cry Easily ❑ Frustration
  - ❑ Mood-swings ❑ Poor memory ❑ Easily irritable ❑ Foggy thinking
  - ❑ Explosive outbursts
  - ❑ Difficulty making decisions
  - ❑ Obsessive/repetitive thinking
  - ❑ Tendency to hold things in

If you experience mood-swings, are they related to eating/not-eating? _____

If you are female and have mood-swings, are they related to your menstrual cycle? _____

Chronic Pain

- ❑ Do you suffer from chronic or occasional backache or neck-ache
- ❑ Do you suffer from chronic or occasional joint pain

If so, which joints? _____

- ❑ Do any muscles ache or cramp ❑ Do you get muscle twitches or spasms
- ❑ Is your pain worse with certain weather conditions

If so, what type of weather? _____

- ❑ Do you get frequent headaches/migraines

If so, what is the location of the pain? (frontal, occipital, temporal, vertex, center of brain)

_____

Is the pain: ❑ dull/achy ❑ stabbing ❑ burning ❑ empty
❑ like a band wrapped around your head ❑ pressure behind the eyeballs
❑ other _____

General Health

Do you have or experience:

- ❑ Dizziness or vertigo
- ❑ Tinnitus (ear ringing)
- ❑ Any hearing loss
- ❑ Unusual hair loss or premature graying
- ❑ Tooth decay/looser teeth
- ❑ Gum problems/bleeding
- ❑ Aversion to cold
- ❑ Tingling or numbness sensations
- ❑ Color blindness
- ❑ Sweating more than normal
- ❑ Sweat with a particularly strong odor

- ❑ High stress level
- ❑ Lump in your throat
- ❑ Regular exercise
- ❑ Grinding your teeth
- ❑ Clenching your jaw
- ❑ Jaw pain or TMJ
- ❑ Tremors
- ❑ Flank or rib pain/discomfort

- ❑ Recent rapid weight gain/loss
- ❑ Frequent nausea
- ❑ Preference for warm/cold foods
- ❑ Eyes sensitive to light
- ❑ Frequent colds/flu

- ❑ Heart palpitations
- ❑ Irregular heartbeat
- ❑ Bruise easily
- ❑ Shortness of breath
- ❑ Shallow breathing
- ❑ Blurred vision
- ❑ Night blindness
- ❑ Chest pain/oppression
- ❑ Sweating less than normal
- ❑ Sweat that stains clothes yellow
- ❑ Earaches/discharge from your ears

- ❑ Mouth/tongue sores
- ❑ Sighing a lot
- ❑ Aversion to heat
- ❑ Aversion to wind
- ❑ Red face or eyes
- ❑ Acne
- ❑ Skin rashes/itching
- ❑ Slowly healing cuts

- ❑ Brittle nails/nails break easily
- ❑ Nails with ridges, spots or lines
- ❑ Eyes tearing or straining easily
- ❑ Frequent twitches in eye/eyes
- ❑ Pale color under eyelids

Men Only

Do you have or experience:

- ❑ Reduced sexual drive
- ❑ Premature ejaculation
- ❑ Ejaculations during your sleep
- ❑ Prostate problems
- ❑ Dribbling urine

- ❑ Impotence
- ❑ Genital pain
- ❑ Unusual discharge
- ❑ Painful/burning urination
- ❑ Uneven force in your stream of urine

Women Only

	YES	NO
Do you have regular pap tests?	❑	❑
Do you receive or give yourself regular breast exams?	❑	❑

Do you have a history of:

❑ Amenorrhea	❑ Menstrual cramps	❑ Ovarian cysts
❑ Ectopic pregnancy	❑ Pelvic Inflammatory Disease	❑ Endometriosis
❑ Uterine fibroids	❑ Irregular periods	❑ Reduced sexual drive
❑ Vaginal discharge	❑ Chronic vaginal or yeast infections	

Birth Control History

Birth control pills _____ Number of years _____

IUD _____ Number of years _____

Abortion(s) _____ Number _____

Following birth, abortion or miscarriage, were there any health problems? If so, please explain.

Menstrual History

Are you currently pregnant? _____ Number of children _____

Age of menarche _____ Have you had a hysterectomy? _____

Are you presently suffering from menopausal disorder? ___ hot flashes? ___ night sweats?___

Please give the following information about your periods. If you no longer have periods, indicate what they were like before they stopped.

	YES	NO
Is your period regular?	❑	❑
Are your periods painful?	❑	❑
Do you bleed excessively?	❑	❑
Do you bleed too little/scanty?	❑	❑
Do you discharge clots?	❑	❑
Do you have headaches before your period?	❑	❑
Do you get headaches after you bleed?	❑	❑
Do you experience tightness in your chest?	❑	❑
Do you experience low backache?	❑	❑
Do you tend to sigh a lot?	❑	❑

How many days between your periods? _____ How many days do your periods last? _____

Is your menstrual blood bright red, pale red, dark red, or rusty colored? _____

Do you suffer from premenstrual syndrome (PMS)? ❒ Yes ❒ No

❑ Breast distension/swelling	❑ Breast lumps	❑ Water retention
❑ Emotional changes	❑ Irritability	❑ Breast tenderness
❑ Pain/cramps relieved by bleeding	❑Pain/cramps made worse by bleeding	

Other: _____

Family Medical History

Please indicate any illness or disorders that have occurred in your immediate family (include parents, siblings, and grandparents)

❑ Diabetes ❑ Cancer ❑ High Blood Pressure ❑ Heart Disease
❑ Stroke ❑ Seizures ❑ Asthma ❑ Allergies ❑ Substance Abuse

❑ Other_____

Disease History

Please indicate if you have had any of the following:

	Past	*Present*		*Past*	*Present*
Allergies	❑	❑	Heart Murmur	❑	❑
Angina	❑	❑	Heart Attack	❑	❑
Anemia	❑	❑	Heat Stroke	❑	❑
Arthritis	❑	❑	Hepatitis	❑	❑
Asthma	❑	❑	Irritable Bowel Syndrome	❑	❑
Blood Pressure Problems	❑	❑	Kidney Stones	❑	❑
Cancer	❑	❑	Mental Illness	❑	❑
Candida	❑	❑	Mononucleosis	❑	❑
Chronic cough	❑	❑	Prostate Problems	❑	❑
Cold Sores	❑	❑	Serious or prolonged fever	❑	❑
Diabetes	❑	❑	Shingles	❑	❑
Eating Disorders	❑	❑	Sinus infections	❑	❑
Edema	❑	❑	Skin problems	❑	❑
Epilepsy	❑	❑	Ulcers	❑	❑
Epstein-Barr Syndrome	❑	❑	Venereal Disease	❑	❑
Food Allergies	❑	❑	Varicose Veins	❑	❑
Gallstones	❑	❑	Irregular Heartbeat/Arrhythmia	❑	❑
Genital Herpes	❑	❑	High cholesterol	❑	❑

Other: _____

Drug History

Please indicate past or present use of the following:

	Past	*Present*	*Years usage*
Anti-depressants	❑	❑	_____
Antibiotics	❑	❑	_____
Estrogen/birth control pills	❑	❑	_____
Pain medication	❑	❑	_____
Prednisone/other steroids	❑	❑	_____
Sleeping pills	❑	❑	_____
Tagamet/other antacids	❑	❑	_____
Thyroid medication	❑	❑	_____
Valium/tranquilizers	❑	❑	_____
Alcohol (in excess)	❑	❑	_____
Tobacco	❑	❑	_____