Victoria Ryan, L.Ac., LCSW, LADC

Patient Intake Form

Name: _____
Street Address: _____
City, State, Zip: _____
Home phone: _____Cell phone: _____
email address: _____DOB: _____

Name of Primary Care Physician: _____phone # _____
Name of Gynecologist/Obstetrician: _____phone #_____

Reason for Seeking Treatment _____

General Medical Background:

Do you have any medical conditions I should know about? _____

What medications do you take on a regular basis? _____

For what? _____

Describe any injuries, surgeries or major illnesses you have had: (include age and length of illness, etc.)

a) BIRTH _____

b) CHILDHOOD _____

c) ADULTHOOD _____

Do you have any scars or calluses? YES NO Where?

Family medical history

Mother _____

Father _____

Grandparents _____

Siblings _____

Diet and Food

How is your appetite? _____

Food cravings? _____

List any vitamins or supplements you are taking: _____

Describe your typical meal:

Breakfast: _____

Lunch: _____

Dinner: _____

What do you like to snack on? _____

Do you smoke cigarettes/cloves/marijuana? If yes, how much per day? _____

How many glasses per day of: Water _____ Soda ____ Coffee/Tea _____ Wine/Beer _____ Mixed drinks ____

Rate your taste preferences from 1-5, 1= like most, 5 =like least: __ Sweet__ Sour__ Salty __Spicy __Bitter

Gastrointestinal

Do you experience now, or have you experienced in the past, any of the following:

___belching ___ nausea ___vomiting ___ulcers ___bloating ___heartburn ___acid regurgitation ___ hernia

___indigestion ___ severe stomach pain ___painful bowel movements ___constipation ___hard stool ___diarrhea

___ loose stools ___undigested food in stool ___hemorrhoids ___ anal itching ___ blood in stool

Urogenital

Urination: ____ times per day Color: (circle) pale yellow - medium yellow - dark yellow/orange

Ever have: _____ trouble starting stream _____frequent urination _____incontinence _____ pain on urination

_____ dribbling when sneezing _____ UTI _____bladder infection _____blood in urine _____kidney stones

Aches and Pains

Describe any physical pain you currently experience _____

_____

Are you prone to headaches? YES NO Describe when and where _____

Cardiovascular

Blood pressure: _____ /_____ Have you ever been diagnosed with heart trouble ? YES NO

Do you experience now or have you experienced in the past, any of the following:

_____ chest pain _____ palpitations _____ varicose veins _____ phlebitis _____cold hands & feet

_____ irregular heart beat _____ poor circulation _____ anxiety _____ depression _____ other _____

Have you ever been diagnosed with a sexually transmitted disease ? YES NO
Have you been tested for HIV? YES NO

Any other medical or psychological issues you would like to discuss?

_____

Gynecological background:

Age of first menstruation: ____ Date of last menstrual period: ____ Average# days between cycles : ____

Average # of days of bleeding: _____

Any questions or information you feel is important/unusual about your monthly cycle? _____

_____

How is your sexual energy? Please report any concerns you may have: _____

_____

Did you ever take birth control pills? YES NO How long and when did you stop?_____

Total # of pregnancies: _____ Live births: ____ Miscarriages: _____ Terminations _____

Have you ever received a Western medical diagnosis for any gynecological problem? YES NO

If yes, what and when was the diagnosis? _____

How has it been resolved? _____

Do you experience now or have you experienced in the past, any of the following:

____ pain during intercourse ____irregular menstruation ____ large clots during menstruation

____ vaginal itching/burning ____ spotting between periods ____ long periods

____ "PMS" symptoms ____ pain before or during menstruation ____ pain after menstruation

____ vaginal discharge: when? _____ regular cervical mucus discharge color? _____

Explain anything checked above: _____

Do you experience symptoms you associate with menopause? If so please list: _____

_____

Are you currently trying to get pregnant? YES NO If not, please skip to page 5
Are you currently pregnant? YES* NO

If yes, due date of baby _____ gender if you know _____

Have you had any complications so far during this pregnancy? _____

Any complications during previous pregnancies? _____

Were you ever on bed rest or modified activities while pregnant? YES NO N/A

Have you ever been diagnosed with diabetes or hypertension while pregnant? YES NO N/A

*Though acupuncture is generally safe, there are increased risks during pregnancy that will be explained. You are encouraged to discuss your desire for acupuncture treatment with your obstetrician and gain his/her consent. You will be required to sign a separate consent form.

Fertility

How long have you been having "unprotected" sexual relations in effort to conceive? _____

Are you charting your temperature on a daily basis? YES NO **If yes, please provide copies of charts.**

If you are not taking your temperature, what other methods are you utilizing to determine when you are ovulating?

_____

Have you seen your gynecologist or a Reproductive Endocrinologist to address trying to conceive? If so, please provide blood work levels for the following:

_____FSH _____ LH _____ estradiol _____ progesterone _____ other

have you had your thyroid tested? If so, what is your TSH level? _____T3? _____ T4? _____

Do you know if you have any structural problem that may be preventing pregnancy? YES NO

Have you had a hysterosalpingogram (HSG)? YES NO Results _____

Any other procedures like an endometrial biopsy, laparoscopy? If so for what reason/findings?_____

_____

If you were born before 1972, do you know if your mother was given DES while pregnant with you? YES/ NO

Do you have a history of any of the following that you know of:

_____uterine fibroids _____ ovarian cysts _____endometriosis _____ polycystic ovary

Has your partner's sperm been tested for abnormalities? **If testing has been performed, please provide a copy of results.**

Have you used any assisted reproductive technology (ART)? If so, which of the following:

_____ IUI un-medicated Date: _____ Results: _____

_____ IUI medicated Date: _____ Results: _____

_____ IVF Date: _____ Results: _____

_____ ICSI Date: _____ Results: _____

Are you planning to try again with ART? YES NO If so, when? _____

Have you discussed with your doctor combining ART with acupuncture treatment? YES NO

Anything else you think I should know about your gynecological history or efforts trying to conceive a child?

_____

_____

Victoria Ryan, L.Ac., LCSW, LADC

Consent for Treatment

I, _____voluntarily consent to be treated with acupuncture by Victoria Ryan, hereinafter referred to as "the acupuncturist".

By initialing next to each item and signing my name below, I certify that I have read and fully understand all the information described and give my permission to be treated with acupuncture. I may also ask the acupuncturist for more detailed information before initialing or signing this form and my consent can be withdrawn at any time.

A. As part of treatment with acupuncture, one or more of the following modalities may be incorporated:

____ **1. Acupuncture**. This is the insertion of very fine, sterile, filiform needles into specific acupuncture points in the body recognized to be effective for specific health problems.

____ **2. Electro-Acupuncture**. This is the addition of small electrical currents through the acupuncture needles. Electro-stimulation is often used in conjunction with acupuncture as it has been shown to decrease pain, accelerate tissue healing, and reduce inflammation and swelling.

____ **3. Moxabustion**. This is the process of burning an herb called Mugwort. It results in the application of heat to the skin and can be used either directly via loose moxa placed on the body over a layer of protective cream or indirectly with a moxa pole. It is most often used in conditions with the presence of cold.

____ **4. Cupping**. This technique involves creating a vacuum under several glass "cups" and placing them on the body. The suction created by the cups stimulates circulation and is used for many conditions, including back pain and common colds. The treatment leaves purple or red circles at the site of cupping which fade in a few days.

____ **5. Chinese Herbs**. Herbal therapy may be recommended to enhance wellness. If I wish to take herbs, I must do so per written and verbal instructions of the acupuncturist. Side effects are rare, but should I experience any uncomfortable changes that I associate with taking the herbs, I will discontinue use and contact the acupuncturist immediately. Symptoms may include, but are not limited to, changes in bowel habits, abdominal pain or discomfort, headache, gas, nausea or vomiting, rashes, hives and/or a tingling sensation of the tongue.

____ **6. Nutritional Counseling.** Chinese dietary therapy is one of the pillars of Chinese medicine. The use of food as medicine is deeply rooted in Chinese culture and specific dietary recommendations may be made as part of my treatment.

B. _____ I will notify the acupuncturist if I am trying to get pregnant OR suspect I am pregnant.

C. _____ I understand that there are treatment alternatives, which may be better suited to address my condition. I understand that an acupuncturist is not a medical doctor and I have been advised by the acupuncturist to discuss my condition(s) with my primary healthcare provider.

D._____ I am aware that that while acupuncture is generally safe, there are potential side effects to treatment such as drowsiness, possible bruising or bleeding and that symptoms can intensify before they lessen. Other more <u>rare</u> occurrences include spontaneous miscarriage, nerve damage or organ puncture, including lung puncture (pneumothorax).

Infection is also another possible risk however the acupuncturist uses only sterile and disposable needles which are inserted one time and then discarded to minimize this risk. Should I experience any adverse symptoms for more than 24 hours I will contact the acupuncturist as well as my primary healthcare provider. Should I have any difficulty breathing, no matter how slight, I will call 911 or go to the nearest emergency room immediately.

Signature: _____ Date: _____

Print Name: _____

Victoria Ryan, L.Ac., LCSW, LADC

Notice of Privacy Practices

This notice describes how health information about you is protected or may be used and disclosed and how you can gain access to this information. Please review it carefully.

Respect for patient privacy is highly valued. Confidentiality of all information that may reveal your identity will be maintained as required by law.

Required permission to use and disclose your protected health information (PHI)

I will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment for that treatment and conduct operations specific to my practice. This general written consent will be obtained the first time I provide you with treatment or services. This consent gives broad, general permission that does not need to be repeated each time I provide you with treatment or services. At times, other more specific consent may be obtained for particular services including, but not limited to providing acupuncture during the last weeks of pregnancy, or should specific information need to be disclosed to or obtained from a third party in effort to ensure that all providers are working together to ensure you receive appropriate care.

How I may use and disclose your health information

Health information about you is used for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care you receive. Health information about you may be disclosed to other practitioners for educational purposes or for continuity of service should another practitioner see you in my absence.

Your Rights

You have the right to look at health information about you. You may request in writing, to receive a copy of any information at a copying charge of ten (10) cents per page. If you believe that information in your record is incorrect, you have the right to request that such information be corrected.

My Legal Duty

I am required by law to protect the privacy of your information, provide this notice about my information sharing practices, follow such practices as described and seek your acknowledgement of this notice. You will be notified in writing of any significant changes in my personal policies or changes in policies dictated by law.

Please note that as a Mandated Reporter, I am required by law to report any suspect of child abuse, child endangerment or neglect to the proper authority.

Complaints

If you are concerned that I have violated your privacy rights or you disagree with a decision I made about access to your records, you may contact:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Telephone: 202-619-0257/877-696-6775

Patient Signature _____ Date Signed: _____

Patient Acknowledgement of receipt of copy (please initial): _____

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