

INTAKE FORM

Please answer the following questions to the best of your ability to enable a more complete assessment of your condition.

Name:

Date:

Address:

City:

State:

Zip:

Daytime phone:

Home phone:

Cell phone:

Sex:

Marital status:

Height:

Weight:

Birthdate:

Profession:

E-mail address:

Place of birth:

How were you referred to the Berkley Center for Reproductive Wellness?

Friend ____ Relative ____ Seminar ____ Internet ____ Other _____

Physician:

FAMILY HISTORY

Illness	Father	Mother	Sibling(s)	Spouse	Children
Cancer					
Diabetes					
High Blood Pressure/ Heart Disease					
Allergies (food, dust, etc.)					
Drug Abuse					
Mental Illness					
Other					

Other Comments:

INFECTIONS SCREENING

(Please check if true)

- Engage in safe sex
- HIV risk: self or partner
- TB risk: self or partner
- Hepatitis: self or partner
- Blood transfusions

GENERAL HEALTH HISTORY

1. Please describe in detail the main problem(s) you would like to address. Include the onset, progression, aggravating and alleviating factors. How does this condition affect your life? Please rank your problem on a scale of 1 to 10 (where 1 is mild and 10 is severe):

2. On a scale of 1 to 10, how is your energy level (1 being the worst and 10 being the best)? Do you experience an energy slump at any particular time of day?

3. **Urination:** Do you experience any frequency, urgency, burning, dribbling? Do you notice any abnormal coloration? History of urinary tract infections or other urinary dysfunction?

4. **Bowel movement:** Are they regular, once a day, twice a day, every other day, etc.? Do you ever experience diarrhea, constipation, alternation of the two, etc.? Any history of large intestine problems?

5. Do you experience any sensations of heat or cold? Do you prefer warmth, lots of sweaters and blankets? Or are you comfortable wearing T-shirts during colder weather?

6. How is your appetite?

7. Do you have any abnormal thirst, dry mouth or throat?

8. Do you experience night sweats? Sweating upon slight exertion?

9. Please describe in general what you eat. Do you eat a lot of sweets or any particular foods? Do you crave salty foods? Sweets?

10. Do you experience digestive difficulties? Do you experience any bloating, reflux, gas, ulcers?

11. Do you have any known heart problems? Do you experience heart palpitations or fluttering?

12. Do you have any respiratory problems such as asthma, etc.? Do you experience shortness of breath?

13. Do you have ringing in the ears, low or high-pitched? Stuffy sensation in the ears?

14. Do your eyes ever burn, itch or tear? Do they feel gritty or dry? Do you have floaters in your eyes?

15. Do you fall asleep easily or have initial insomnia? Do you wake up in the middle of the night and have difficulty falling asleep again? Do you wake up feeling rested? Do you have vivid dreams or nightmares? Do your dreams center around any particular themes and if so, what?

16. Do you have any propensity to catch colds or get sick frequently?

17. If you smoke, consume alcoholic or caffeinated beverages, and/or engage in any other recreational drugs, please describe frequency and amount.

18. Please list all herbs and supplements you are currently taking along with dosage.

19. For Females:

GYNECOLOGIC HISTORY

When was the first day of your last period? _____

Are your periods regular? Yes _____ No _____

Age at first period? _____ Days between periods _____ Days of bleeding? _____

Amount of bleeding: Light _____ Medium _____ Heavy _____

Have you ever needed medication to bring on your period? Yes _____ No _____

Pain with menstruation? Yes _____ No _____

Degree of pain: Mild _____ Moderate _____ Severe _____

Pain relieved by over the counter medications? Yes _____ No _____

Starts with the onset of bleeding? Yes _____ No _____

Begins a few days prior to the onset of bleeding? Yes _____ No _____

Persists more than 48 hours? Yes _____ No _____

Do you have pain with ovulation? Yes _____ No _____

Do you experience pain with sexual intercourse? Yes _____ No _____

Pain is mostly on the exterior? Yes _____ No _____

Pain is mostly internal (deep penetration)? Yes _____ No _____

Do you experience painful ovulation? Yes _____ No _____

Are you experiencing a vaginal discharge? Yes _____ No _____

Associated with itching or burning? Yes _____ No _____

Associated with an unusual odor? Yes _____ No _____

Do you have a Gynecologist? Yes _____ No _____

When was you last Pap Smear? _____

Result? _____

Have you ever had an abnormal Pap Smear? Yes _____ No _____

If yes, what follow up was needed? _____

Have you ever had a Mammogram? Yes _____ No _____

Have you ever had a sexually transmitted disease?
(i.e. Chlamydia, Gonorrhea, Syphilis, Herpes) Yes _____ No _____

When? _____ Was it treated? Yes _____ No _____

Have you ever had Pelvic Inflammatory Disease (PID)? Yes _____ No _____

When? _____

Were you Hospitalized? Yes _____ No _____

Do you experience milk or discharge from your breasts? Yes _____ No _____

Have you ever used an IUD? Yes _____ No _____

Have you ever used the Oral Contraceptive Pill? Yes _____ No _____

How many years? _____

When did you last use it? _____

PREVIOUS SURGERIES

Have you ever had surgery?

Procedure	Date	Indication	Outcome

Are you currently pregnant: Yes No

OBSTETRICAL HISTORY

How long have you been trying to have a baby? _____ years

Have you ever been pregnant before? Yes _____ No _____

Date	Current or Prior Partner	Live Birth (Y/N)	Miscarriage, Abortion, Ectopic Pregnancy	Wks	Fetal Heart (Y/N)	D&C (Y/N)	Mode of Delivery	Sex	Wt.	Complications Comments

MEDICAL CONDITIONS

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

Condition	Yes/No	Comments
German measles (Rubella)		
Migraine		
Prolonged dizziness		
Glasses/ contact lenses		
Thyroid problems		
Pneumonia		
Tuberculosis		
Asthma		
Bronchitis		
Other lung conditions		
Heart attack		
Heart murmur		
Rheumatic fever		
Other heart conditions		
High blood pressure		
Gastric/duodenal ulcer		
Hepatitis		
Cirrhosis		
Intestinal bleeding		
Bleeding tendency		
Problems with anesthesia		
Diabetes		
Kidney stones		
Kidney infection		
Other kidney disorders		
Bladder infection		
Rheumatoid arthritis		
Other forms of arthritis		
Lupus erythematosus		
Paralysis		
Neurologic disorders		
Thrombophlebitis		
Varicose veins		
Breast tumor (benign)		
Breast Cancer		
Ovarian cancer		
Uterine cancer		
Other Cancer		
Other		

MALE HISTORY

Occupation: _____

Have you initiated any pregnancies in the past? Yes _____ No _____

Number of pregnancies? _____

Number with current partner? _____

When was the most recent pregnancy? _____

Have you been evaluated by an Urologist? Yes _____ No _____

Diagnosis: _____

Have you ever had a semen analysis? Yes _____ No _____

Results:

Date _____

Count (Million cell/ml) _____

Motility (%) _____

Morphology (% normal forms) _____

Other _____

Are you allergic to any medications? Yes _____ No _____

Medication: _____ Reaction: _____

Are you taking any medications? Yes _____ No _____

Medication: _____ Dose: _____ Frequency: _____

Do you use Tobacco? Yes _____ No _____ #Packs/day _____

Do you use Alcohol? Yes _____ No _____ #Drinks/wk _____

Do you use a hot tub? Yes _____ No _____ #Times/wk _____

Have you had any of the following tests or procedures?

Test/ Procedure	Date	Result	Comment
Blood Tests			
FSH			
LH			
Testosterone			
TSH			
Antisperm antibodies			
DQ Alpha			
Semen Tests			
Hamster egg penetration			
Fructose			
Semen culture			
Surgery			
Vasectomy			
Vasectomy reversal			
Testicular biopsy			
Varicocele ligation			
Hernia repair			
Undescended testicle			
Removal of testicle(s)			
Other			

DRUG ALLERGIES

Are you allergic to any medications that you know of? Yes _____ No _____

Medication	Reaction

CURRENT MEDICATIONS

Are you currently taking any medications? Yes _____ No _____

Medication	Dose	Frequency

20. Please list all major emotional events in your life and approximately when they occurred. Please list any emotional events, whether or not you think they are major, that occurred within 6 months of the onset of your chief complaint. If there was an event but you do not want to disclose it, please indicate that and the approximate date.

21. How often have you taken antibiotics?

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

22. How often have you taken oral steroids?

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

23. Childhood:

Question	Yes	No	Don't know	Comment
When your mother was pregnant with you, did she:				
a. Smoke tobacco?				
b. Drink alcohol?				
c. Take estrogen?				
d. Were you a full term baby?				
e. A preemie?				
f. Breast fed?				
g. Bottle fed?				
j. As a child, did you eat a lot of sugar and/or candy?				

24. Please add anything else you feel we should know about:

Signature: _____ **Date:** _____

CANCELLATION & RESCHEDULING POLICY

We understand that there are times when you will need to cancel and/or reschedule your appointment. We are pleased to accommodate your needs.

It is our policy, however, that all cancellations and/or rescheduling must be done at least two business days prior to the date of your appointment.

A fee of \$50.00 will be charged if your cancellation/re-scheduling is not done two business days prior to the date of your appointment.

Thank you for your understanding.

Please sign here indicating that you understand and accept this policy:

Patient Signature

Date

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future treats me while employed by, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office or clinic.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, Gua Sha, electrical stimulation, Tui Na (Chinese Massage), Chinese or Western herbal medicine and nutritional counseling

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of the acupuncture treatments and other procedures.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been extremely rare instances reported of fainting, infection and scarring. There have been extremely rare instances of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping and/or Gua Sha.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels, at the time, based upon the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE (page 2)

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content.

By signing below, I agree to the above-named procedures. 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.

To be completed by the patient:

Patient's Name: _____

Signature: _____

Date: _____ Are you pregnant? Yes No Maybe

To be completed by the patient's representative, if necessary, i.e. if the patient is a minor or is physically or legally incapacitated:

Patient's Name: _____

Patient's Representative: _____

Relationship of Authority: _____

Witness: _____

Date: _____

The Berkley Center Practitioners

Mike Berkley, L.Ac., Board Certified Herbalist; FABORM

ADVISE TO CONSULT A PHYSICIAN

We, the undersigned, do affirm that _____ has been advised by Mike Berkley, L.Ac., to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

I, _____ have received a copy of this document.
please print your name

Patient Signature

The Berkley Center Practitioners

Mike Berkley, L.Ac., Board Certified Herbalist; FABORM

Date

ADVISE TO CONSULT A PHYSICIAN

We, the undersigned, do affirm that _____ has been advised by Mike Berkley, L.Ac., to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

I, _____ have received a copy of this document.
please print your name

Patient Signature

The Berkley Center Practitioners

Mike Berkley, L.Ac., Board Certified Herbalist; FABORM

Date