wholefamily health

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Gender Neutral Fertility Forms

Date:

Last name / First name / Circle: Miss Ms. Mrs. Dr.

Birth date / Age / Circle # of preferred contact

Address / Phone (home) /

City / Phone (work) /

Province / Postal Code / Phone (cell) /

Email / Occupation /

Height / Weight /

Reason for Visit /

Have you had Acupuncture before? Yes No

Chinese herbal medicine? Yes No

Family Physician name / Family Physician phone /

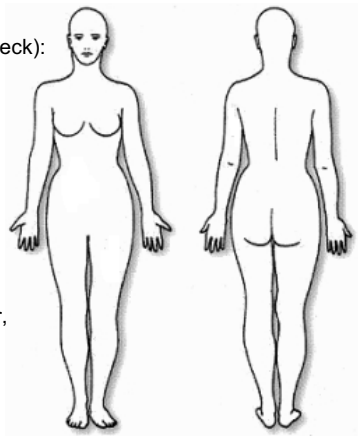
Western Medical diagnosis (if applicable) /

Other medical treatment received (circle) / Physiotherapy Massage Naturopathy Chiropractic Other:

Please indicate with a '**P**' (past) '**C**' (current) '**F**' (family) if any of the conditions below apply:

	Heart conditions		Stroke		High blood pressure		Low blood pressure
	Diabetes		Deep vein thrombosis		Neurological condition		Spinal or head injury
	Respiratory condition		Kidney disorder		Cancer		Hepatitis
	HIV / AIDS		Sprain/strain/fracture		Osteoporosis		Headaches/migraines
	Jaw pain		Arthritis		Dizziness/fainting		Contagious illness
	Skin condition		Digestive problems		Haemophiliac		Wear a pacemaker
	Lung condition		Epilepsy		Possibility of pregnancy		Upcoming surgeries

On the figures below, please circle the areas of concern/pain;



Sensations/pain characteristics (check):
Sharp __ Burning __ Moving __
Tingling __ Dull __ Severe __
Stabbing __ Shooting __
Throbbing __ Numbness __

What relieves the pain (ice, rest, activity, massage, heat…)?

_____

_____

What aggravates the pain (weather, heat, cold, rest, activity…)?

_____

_____

Please list any prescription medication or over the counter drugs currently taking:

1.	2.
3.	4.
5.	6.

Please list herbal medicine and other supplements currently taking:

1.	2.
3.	4.
5.	6.

Please list any allergies (food, drugs, environmental, etc.):

1.	2.
3.	4.

Have you been hospitalized and/or treated for any infectious/serious conditions or surgeries? If yes, briefly explain for what condition or reasons and the year (below).

Do you use the following? If so how often? Cigarettes: _____ Alcohol: _____ Drugs: _____ Coffee: _____ Pop: _____

Do you participate in the following physical activities? If so, please indicate how often:

Yoga:	Running:	Fitness Class:	Gym:
Biking:	Swimming:	Walking:	Other:

How did you hear about Whole Family Health? (Internet, Friend, Doctor, Seminar, Magazine, TV, News, etc.) _____

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For each symptom below that you currently have, rate its severity from 1-5 (5 being worst). Leave blank if N / A.

Gan
___ Irritability / frustration / impatience
___ Depression
___ Stress
___ Emotional eating
___ Unfulfilled desires
___ Visual problems / floaters
___ Blurred vision / poor night vision
___ Red / dry / itchy eyes
___ Headaches / Migraines
___ Dizziness
___ Feeling of lump in throat
___ Muscle twitching / spasm
___ Neck / shoulder tension
___ Brittle nails
___ Sighing
___ Sensation or pain under rib cage
___ PMS
___ Genital itching / pain / rashes

Xin
___ Palpitations
___ Chest pain / tightness
___ Insomnia / sleep problems
___ Restless / easily agitated
___ Vivid dreams
___ Lack of joy in life
___ Forgetful
___ Aversion to heat
___ Bitter taste in mouth
___ Tongue / mouth ulcers / cankers

Shen
___ Frequent urination
___ Bladder infection
___ Lack of bladder control
___ Wake to urinate
___ Feel cold easily
___ Cold hands / feet
___ Night sweats / hot flushing
___ Low sex drive
___ High sex drive
___ Loss of head hair
___ Hearing problems
___ Crave salty food
___ Fear
___ Poor long term memory
___ Ankle swelling
___ Tinnitus

Fei
___ Dry cough
___ Cough with phlegm
___ Nasal discharge / drip
___ Sinus infection / congestion
___ Itchy / painful throat
___ Dry mouth / throat / nose
___ Skin rashes / hives
___ Snoring
___ Grief / sadness
___ Shortness of breath
___ Allergies / asthma
___ Weak immune system
___ Alternate fever / chills

Pi
___ Heaviness in the head / body
___ Fatigue after eating
___ Difficult getting up in morning
___ Water retention
___ Muscular tired / weak
___ Bruise easily
___ Unusual bleeding (stool, nose, etc)
___ Bad breath
___ Poor appetite
___ Increased appetite
___ Crave sweets
___ Poor digestion
___ Nausea / vomiting
___ Bloating / gas
___ Hemorrhoids
___ Constipation
___ Loose stool
___ Alternate constipation / loose
___ Abdominal pain
___ Intestinal pain / cramping
___ Heartburn
___ Pensive / over-thinking
___ Overweight
___ Foggy mind
___ Yeast infection
___ Aversion to cold
___ Cold nose
___ Increased thirst
___ Prefer warm / cold drinks
___ Sweat easily

List your main health concerns in order of importance to you:	1.	2.
	3.	4.

On a scale of 1-10, how would you rate your daily energy level (10 being best)?

How many glasses of water do you drink in a day?

What is your occupation? Do you enjoy your work? How many hours per week do you work? Is it stressful? What are your duties?

Please describe in general what you eat, and what you crave. (sweet, spicy, salty, organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.)

Are your bowel movements regular? How many times per day/week? Are they formed, loose, constipated, or do they alternate from loose to difficult to pass?

Do you have trouble falling asleep? Are you a light sleeper? How many hours per night? Do you have vivid dreams? If so, what are they about? Do you wake and have difficulty falling back to sleep?

Do you experience urinary frequency, urgency, burning, dribbling, retention? What colour/shade of yellow is it? Do you have a history of urinary tract infections?

If you were asked to describe yourself from an emotional standpoint, what would you say (i.e. irritable, worrier, anxious, sad, impatient, stressed, etc.)?

How many times (approx.) in your life have you taken antibiotics? How many times have you taken oral steroids?

What brings you joy? (hobbies, passions, etc)

Are you currently undergoing assisted reproductive treatments (IUI, IVF, ICSI, superovulation, etc.)? ___ Yes ___ No

If yes, at what fertility clinic? _____

Have you undergone assisted reproductive treatments in the past? (IUI, IVF, ICSI, superov, etc.) __ Yes __ No

Month/Year	Type of treatment	Clinic	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you currently have a partner? __ Yes __ No

If yes: are you trying to conceive a biological child with your partner? __ Yes __ No

If yes: how long have you been trying to conceive together? _____

has your partner had a Western medical diagnosis relating to fertility? __ Yes __ No

If yes, what was the diagnosis? _____ Who made the diagnosis? _____

Are you using donor sperm? __ Yes __ No

If yes, are you using a known donor? __ Yes __ No

Are you using donor eggs? __ Yes __ No

If yes, are you using a known donor? __ Yes __ No

Are you using donor embryos? __ Yes __ No

If yes, are you using a known donor? __ Yes __ No

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If you are creating a pregnancy with your own eggs and/or your own uterus, please fill out the following relevant information:

Date last menses began /

Is your menstrual cycle: Regular ___ Irregular ___

How old were you when you had your first menstruation?	How many days do you bleed in total? /
	Menstrual cycle length (i.e. 26-30 days) /

Describe your flow: Heavy ___ Light ___ Average ___ **Consistency of blood**: Watery ___ Thick ___ Average ___

Does your blood contain clots? Yes ___ No ___ …and... **At which point during the cycle?** Start ___ Mid ___ End ___

Describe the colour of your blood: (red, dark red, brown, purple, brownish red, bright red, pink, etc)

Do you experience menstrual pain? Yes ___ No __	Before menses ___ During _____(please specify which days) After ___
What relieves the pain?	Stabbing ___ Cramping ___ Dull ___ Heavy ___ On/off ___

Do you experience pre-menstrual symptoms (PMS)? Please check all that apply.

Breast tenderness ___ Cramps ___ Acne ___ Change in bowel ___ Bloating ___ Headaches ___
Nausea ___ Moodiness ___ Fatigue ___ Night sweats ___ Sleep disturbances ___

Please list any other pre-menstrual symptoms

Do you ovulate on your own? Yes ___ No ___ What Day? ____	Do you chart your cycle? (circle) BBT / Ovulation sticks / Saliva
Do you experience pain around ovulation? Yes ___ No ___	Do your breasts get tender around ovulation? Yes ___ No ___
Do you notice stretchy clear egg white slippery cervical mucus around ovulation? Yes ___ No ___	

How many times have you been pregnant? _____ How many times have you given birth? _____
Ages of children _____ Sex of Children _____ Given names_____
Have you had any miscarriages? Yes ___ No ___
If yes, how many, at how many weeks pregnant, and in what year(s)?_____
How many times have you had a D&C preformed? _____
How many abortions have you had? _____ In what year(s)? _____
Were there any problems that occurred during these pregnancies? _____

Have you ever been diagnosed with:

STD? ……	Yes__ No__
Pelvic inflammatory disease?……	Yes__ No__
Uterine fibroids? ……..	Yes__ No__
Polyps? ……	Yes__ No__
Pelvic adhesions?……	Yes__ No__
Prolapsed uterus?……	Yes__ No__
Unique shape of uterus?	Yes__ No__
Endometriosis?……	Yes__ No__
PCOS (polycystic ovarian syndrome)? ……..	Yes__ No__

Date of last pap smear: _____/_____/_____ (dd/mm/yyyy)

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

Have you ever had a cervical biopsy or operation? Yes ___ No ___

Do you get yeast infections regularly? Yes ___ No ___

Do you get bladder infections regularly? Yes ___ No ___

If answered yes, list STDs: _____

Do you experience vaginal discharge? Yes ___ No ___

If yes, what colour?

White ___ Yellow ___ Green ___ Pinkish ___ Red ___

If yes, what consistency?
Watery / thin ___ Thick ___ Sticky ___

If yes, does it have foul odour? Yes ___ No ___
Have you taken oral contraceptives? Yes ___ No ___

If yes, for how long? _____
When did you stop? _____

Have you ever had an IUD? Yes ___ No ___

Have you ever taken Depo-Provera? Yes ___ No ___

Have you had any hormone testing done? (e.g., Day 3, Day 21)			
FSH ……..	___ Low	___ Normal	___ High
Estrogen (E2) ……..	___ Low	___ Normal	___ High
Progesterone ……..	___ Low	___ Normal	___ High
Prolactin ……..	___ Low	___ Normal	___ High
Thyroid (TSH) ……..…	___ Low	___ Normal	___ High
Testosterone ……..…	___ Low	___ Normal	___ High
Other: _____	___ Low	___ Normal	___ High

Have you had a Western medical diagnosis relating to fertility? ___Yes ___ No

If yes, what was the diagnosis? _____ Who made the diagnosis? _____

Have you taken medication to help you ovulate? ___ Yes ___ No

If yes, what kind? _____ For how many cycles? _____

Have you had your uterine/fallopian tubes evaluated medically (HSG)? ___ Yes ___ No

What were the results? _____

Have you had any tubal operations? __ Yes __ No

How is your sexual desire (mental interest)?..... ___ Low ___ Normal ___ High

How is your sexual arousal (physical/orgasm)?..... ___ Low ___ Normal ___ High

Do you use vaginal lubricants?..... ___ Yes ___ No

Have you been exposed to or received chemotherapy or radiation? … ___ Yes ___ No

Do you have excessive facial or body hair? …….. ___ Yes ___ No

Do you have excessively oily skin? …….. ___ Yes ___ No

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If you are creating a pregnancy with your own sperm, please fill out the following relevant information:

Have you ever created a pregnancy with your own sperm?	__ Yes	__ No	
If yes: how many pregnancies?			
how many children and how old are they now?			
how many miscarriages? When and how far along?			
how many terminations?			
Have you ever undergone hormone treatment?	___ Yes	__ No	
If yes: what kind?			
for how long and until when?			
How is your sexual energy/libido?	___ Below normal	___ Normal	
Have you had a recent physical exam?	___ Yes	___ No	
Do you or did you have an undescended testicle?	___ Yes	___ No	
Have you ever been diagnosed with a varicocele?	___ Yes	___ No	
Have you ever had any urologic surgeries?	___ Yes	___ No	
Have you experienced erectile dysfunction?	___ Yes	___ No	
Have you experienced difficulty ejaculating?	___ Yes	___ No	
Have you been exposed to any environmental toxins or hormones?	___ Yes	___ No	
Have you experienced any penile discharge?	___ Yes	___ No	
Do you regularly experience nocturnal emission?	___ Yes	___ No	
Do you have high cholesterol?	___ Yes	___ No	
Have you had a high fever in the past 6 months?	___ Yes	___ No	
Do you currently have any prostate conditions?	___ Yes	___ No	
Do you have or have you ever had urinary infections or STDs?	___ Yes	___ No	
Have you ever taken testosterone supplements/drugs?	___ Yes	___ No	
Have you recently had your testosterone levels checked?	___ Yes	___ No	
Have you been diagnosed with small or soft testes?	___ Yes	___ No	
Have you been checked for a blockage of your reproductive tract?	___ Yes	___ No	
Have you had any fertility testing?	___ Yes	___ No	
If yes, what was your sperm count?	___ Low	___ Normal	Count: _____
What was the sperm motility?	___ Low	___ Normal	Notes: _____
What was the sperm morphology?	___ Abnormal	___ Normal	Notes: _____

Other comments:

On your journey toward parenthood, what expectations do you have of Whole Family Health Wellness Centre? Please list the wellness goals you wish to obtain here:

Please consider letting us know what you need most from us during our time together (check as many as you wish):

____ **Perspective** (provide a fresh or different way of looking at a situation)
____ **Validation** (provide encouragement and acknowledgement)
____ **Message** (share fitting knowledge, opinions, or wisdom)
____ **Energy** (provide positive energy and support)
____ **Advice** (provide recommendations and suggestions)
____ **Feedback** (offer observations, insight, ideas, and opinions)
____ **Solutions** (share solutions to problems or issues)
____ **Plan** (co-develop a plan of action with you)
____ **Structure** (provide support and a check-in structure for you)
____ **Challenge** (provide a challenge to you to stretch or make a change)
____ **Tough love** (when necessary, have the conversations you may least want to have)
____ **Resource** (suggest/refer you to experts, books, tools, assessments)
____ **Caring** (provide listening, patience, safety, and love)
____ **Removed** (you may just want to come and relax, nothing more)

If there is anything else you would like us to know about you in order to make your experience here better, please share it here:

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Patient Information and Consent Form

Please read this information carefully and ask your practitioner if there is anything that you do not understand.

While acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive;
- Minor bleeding or bruising can occur from acupuncture;
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days;
- Fainting can occur in certain patients, particularly at the first treatment.

What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?

- Bruising (looks like a circular hickey) is a common side effect of cupping;
- The herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint, or other odd detached sensations;
- If you have a pacemaker or any other electrical implants;
- If you are pregnant;
- If you have a bleeding disorder;
- If you are taking anti-coagulants (blood thinners) or any other medication;
- If you have damaged heart valves or have any other particular risk of infection.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time.
I wish to rely on my practitioner to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interests. I understand the practitioner 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.

By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, 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 further conditions for which I seek treatment.

Children on the Premises

I understand that when I bring infants and/or children on to the clinic premises, I take sole responsibility for their safety. I understand that clinic staff cannot provide childcare supervision, that there is risk of injury from exposure to clinical equipment and I accept this risk.

Privacy Policy

The information received and collected about our clients/patients from their visit to Whole Family Health is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Whole Family Health, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of Whole Family Health (also, Whole Family Health will not give, share, sell, or transfer any personal information to a third party unless required by law). Under absolutely no circumstances would this communication happen without the signed consent of the client/patient. The client/patient information will be stored both in digital and hard copy format on Whole Family Health premises. On occasion, Whole Family Health may use client/patient information to conduct clinical studies to help us improve upon services provided.

Appointment Policy

Welcome to Whole Family Health Wellness Centre. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy.

Please note **a treatment room has been reserved for you**. With this in mind, if you are going to be more than 15 minutes late, please call to confirm availability. 24 hour notice for cancelled or rescheduled appointments is necessary in order to avoid the cancellation fee. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

_____	_____	
Print name in full	(Print name of representative if represented by another)	
_____	_____	_____
Signature	(Signature of Representative)	Date

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Patient Information Release Request Form

I, _____ (please print name) give full consent so that Whole Family Health Wellness Centre may consult freely with other physicians and healthcare professionals (whose care I am under) regarding any of my medical treatments or relevant information. This could include the exchange of both verbal and written communications (including lab work).

(*to be filled out by your Whole Family Health practitioner*)

The following is an authorization to provide Whole Family Health Wellness Centre with the following information:

- ○ All recent lab work results
- ○ All medical records
- ○ Other: _____

Alberta Health Care Insurance Plan Number (AHCIP) #: _____

I am nineteen years of age or older:

- ○ Yes
- ○ No

Client/Patient Signature: _____ Date: _____

Signature of parent or guardian (if applicable): _____

Thank-you for your prompt attention to this request. Please email information to info@wholefamilyhealth.ca.
If you have any questions, please feel free to contact us.

Whole Family Health Wellness Centre Ltd.