MADISON ACUPUNCTURE & COMPLEMENTARY MEDICINE
Amy Guinther, L.Ac., Dipl.Ac., MS
6402 Odana Rd, Madison WI, 53719 608-467-9711

Men's Health General

Date: _____

Last name: _____ **First name:** _____

Birth date: _____ Age: _____

Address: _____

City: _____ State: _____ Zip code: _____

Email: _____ Occupation: _____

Circle preferred # – Home ph. #: _____ Cell #: _____ Work #: _____

List your main health concerns in order of importance to you:

1. _____
2. _____
3. _____

Medical: Family physician name: _____ Physician phone: _____

Western medicine 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		Hemophiliac		Wear a pacemaker
	Lung condition		Epilepsy		Possibility of pregnancy		Upcoming surgeries

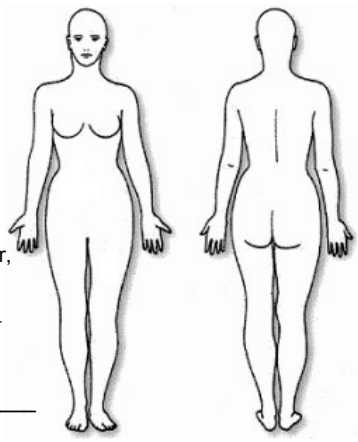
On the figures below, please circle the areas of concern/pain:

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)?
_____

Rate your pain on a scale of 1-10 (10 being most painful): _____



Please list any prescription medication or over-the-counter drugs you are 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 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 my clinic? ? (Internet, Friend, Doctor, Seminar, Magazine, TV, News, etc.)_____

Would you like to receive an email newsletter with health & wellness articles? Yes ____ No ____

Please print, complete and bring forms to your initial appointment. Thank you.

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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.

Liver
___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

Heart
___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

Kidney
___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

Lung
___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

Spleen
___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

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

When was the last time you took antibiotics? _____

How many times have you taken oral steroids? _____ When was the last time you took oral steroids? _____

How often do you have a bowel movement? _____. Is it: formed___ , difficult ___ , loose ___ , alternating_____

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

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

Diet – Please describe your typical diet:

Breakfast: _____

Lunch: _____

Dinner: _____

What do you crave? _____

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

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

MALE FERTILITY FORM (if applicable to your visit)

Name of spouse or partner: _____

How long have you and your partner been trying to conceive? _____

Are you currently undergoing assisted reproductive treatments (IUI, IVF, CSI, superovulation, etc.)? Yes___ No _____

If yes, at what fertility clinic? _____

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:

_____

_____

_____

Treatment Consent Form

By signing below, I do hereby voluntarily consent to be treated by a licensed acupuncturist at Madison Acupuncture & Complementary Medicine, LLC. I understand that Acupuncturists practicing in the state of Wisconsin are not considered to be primary care providers. The practitioner at Madison Acupuncture & Complementary Medicine, advise you to consult a primary care provider in addition to Acupuncture & Oriental medicine treatment.

Acupuncture: I understand that acupuncture is performed by the insertion of single use, sterile needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture is typically a safe method of treatment; however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, infection, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop the acupuncture treatment at any time.

Pregnancy: I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid specific points and herbs that are contraindicated in pregnancy. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

Chinese Herbs & Nutritional Supplements: I understand that Chinese medicinal herbs may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, nausea & vomiting, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call the clinic or your primary care provider.

Acupressure / Tui-Na Massage: I understand that I may also be given acupressure / tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at any time for any reason.

Moxibustion: I understand that moxibustion means the therapeutic application of direct or indirect heat to the skin at certain points on or near the surface of the body. I have been made aware that if I receive direct moxibustion as part of therapy, there is a risk of burning, blisters or scarring from its use. I understand that I may refuse this therapy.

Cupping / Gua Sha: I understand that I may also be given cupping (the application of glass cups with vacuum to the skin) and Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that these treatments are intended to cause minor bruising and though unsightly are not normally painful. However certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at any time for any reason.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Special Situations: Please inform us if you have any allergies, severe bleeding disorders, diabetes, lymphedema, infectious disease-such as HIV / AIDS, hepatitis, tuberculosis, or if you are wearing a pacemaker or other electronic medical device.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks is best at the time based upon the facts then known. I understand that results are not guaranteed. I understand that the acupuncturist is not providing Western (allopathic) medical care, and that I should look to my primary care practitioner (i.e., M.D.) for those services and for routine check-ups.

I request and consent to the performance of acupuncture and Oriental Medicine procedures and nutritional recommendations/ supplementation. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature in this form indicates that I have read and understand the risks and benefits of acupuncture and other treatments. I have had an opportunity to ask questions and understand that if at any time I have any questions about this information, I should ask my acupuncturist. I, hereby release Madison Acupuncture & Complementary Medicine from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

Signature: _____ Date: ____/_____/ _____

Printed Name: _____

Informed Patient Authorization

Patient Name:		Date of Birth: / /
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	

Informed Consent:

The benefits and risks of receiving Acupuncture, Oriental Medicine and nutritional supplementation therapies have been explained to me. Although rare, certain side effects may result from Acupuncture, herbal medicine and nutritional supplementation. I understand a licensed acupuncturist will be performing these treatments. I understand Madison Acupuncture & Complementary Medicine, LLC may record medical and other information concerning my treatments in electronic or other physical form. Such information may be released by the clinic for the purposes outlined on this form. I understand that portions of my medical records may be disclosed to qualified non-clinician personnel for the purpose of conducting scientific or statistical research, management or financial audits without my consent. I understand that no guarantees have been made to me as a result of treatment or medical examination at Madison Acupuncture & Complementary Medicine.

Records Release Authorization:

- I authorize the use of this form for all of my insurance submissions.
- I authorize release of information to all of my insurance companies.
- I permit a copy of this authorization to be used in place of an original.
- I direct my previous, and current, health care providers to release medical records to this clinic.
- I understand that I am fully responsible for my bill.
- I authorize payment directly to Madison Acupuncture & Complementary Medicine.
- I authorize my clinician to act as my agent to obtain payment from my insurance company.
- This authorization is not intended to allow the release of records regarding my treatments for services requiring a restricted release under State and Federal Law.
- I understand a $40 cancellation fee will be charged if I cancel with less than 24 hours' notice.
- I authorize use of the results of my treatment in statistical reports with my identity remaining confidential.

Notice of Privacy Practices:

I have received a copy of the Madison Acupuncture & Complementary Medicine Notice of Privacy Practices paperwork. I understand the paperwork defines my rights under 45 CFR 164.528 of the federal regulations and is intended to comply with federal privacy rights.

_____ Date:_____/_____/_____

Patient's Signature

Consent to Treat a Minor Child:

I authorize the licensed clinicians at Madison Acupuncture & Complementary Medicine to administer Acupuncture and Oriental Medicine care and nutritional supplementation as deemed necessary to my _____ (relationship).

Child's Name: _____ Adult's signature: _____

Date: _____ /_____ /_____

Notice of Privacy Practices

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (*e.g.*, requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you – for example, your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 608-467-9711.

Yours truly,

Amy Guinther, L.Ac., Dipl.Ac., MS

Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Madison Acupuncture & Complementary Medicine, LLC for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at Madison Acupuncture & Complementary Medicine, LLC, may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Madison Acupuncture & Complementary Medicine, LLC is not required to agree to the restrictions that I may request. However, if Madison Acupuncture & Complementary Medicine, LLC agrees to a restriction that I request, the restriction is binding upon Madison Acupuncture & Complementary Medicine, LLC.

I have the right to revoke this consent, in writing, at any time except to the extent that Madison Acupuncture & Complementary Medicine; LLC has taken action in reliance on this consent.

My identifiable health information means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Madison Acupuncture & Complementary Medicine, LLC Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations at Madison Acupuncture & Complementary Medicine, LLC. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and Madison Acupuncture & Complementary Medicine, LLC with respect to my identifiable health information.

Madison Acupuncture & Complementary Medicine, LLC reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

Print name: _____ Date: _____

Signature: _____

Amy Guinther, L.Ac.,Dipl.Ac., MS 6402 Odana Rd, Madison WI 608.467.9711