

Women's General Gynecology

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:

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

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

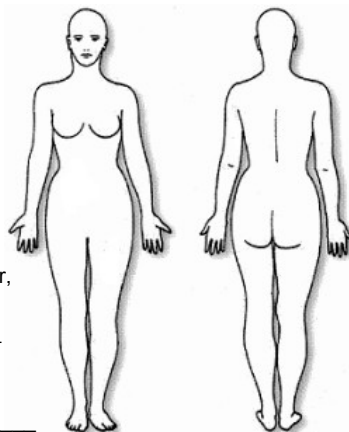
Sensations/pain characteristics (check):

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 ___

For each symptom below that you currently have, rate its severity from 1-5 (5 being worst). Leave blank if N/A.		
<p>Liver</p> <p><input type="checkbox"/> Irritability / frustration / impatience</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Stress</p> <p><input type="checkbox"/> Emotional eating</p> <p><input type="checkbox"/> Unfulfilled desires</p> <p><input type="checkbox"/> Visual problems / floaters</p> <p><input type="checkbox"/> Blurred vision / poor night vision</p> <p><input type="checkbox"/> Red / dry / itchy eyes</p> <p><input type="checkbox"/> Headaches / Migraines</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Feeling of lump in throat</p> <p><input type="checkbox"/> Muscle twitching / spasm</p> <p><input type="checkbox"/> Neck / shoulder tension</p> <p><input type="checkbox"/> Brittle nails</p> <p><input type="checkbox"/> Sighing</p> <p><input type="checkbox"/> Sensation or pain under rib cage</p> <p><input type="checkbox"/> PMS</p> <p><input type="checkbox"/> Genital itching / pain / rashes</p> <p>Heart</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Chest pain / tightness</p> <p><input type="checkbox"/> Insomnia / sleep problems</p> <p><input type="checkbox"/> Restless / easily agitated</p> <p><input type="checkbox"/> Vivid dreams</p> <p><input type="checkbox"/> Lack of joy in life</p> <p><input type="checkbox"/> Forgetful</p> <p><input type="checkbox"/> Aversion to heat</p> <p><input type="checkbox"/> Bitter taste in mouth</p> <p><input type="checkbox"/> Tongue / mouth ulcers / cankers</p>	<p>Kidney</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Bladder infection</p> <p><input type="checkbox"/> Lack of bladder control</p> <p><input type="checkbox"/> Wake to urinate</p> <p><input type="checkbox"/> Feel cold easily</p> <p><input type="checkbox"/> Cold hands / feet</p> <p><input type="checkbox"/> Night sweats / hot flushing</p> <p><input type="checkbox"/> Low sex drive</p> <p><input type="checkbox"/> High sex drive</p> <p><input type="checkbox"/> Loss of head hair</p> <p><input type="checkbox"/> Hearing problems</p> <p><input type="checkbox"/> Crave salty food</p> <p><input type="checkbox"/> Fear</p> <p><input type="checkbox"/> Poor long term memory</p> <p><input type="checkbox"/> Ankle swelling</p> <p><input type="checkbox"/> Tinnitus</p> <p>Lung</p> <p><input type="checkbox"/> Dry cough</p> <p><input type="checkbox"/> Cough with phlegm</p> <p><input type="checkbox"/> Nasal discharge / drip</p> <p><input type="checkbox"/> Sinus infection / congestion</p> <p><input type="checkbox"/> Itchy / painful throat</p> <p><input type="checkbox"/> Dry mouth / throat / nose</p> <p><input type="checkbox"/> Skin rashes / hives</p> <p><input type="checkbox"/> Snoring</p> <p><input type="checkbox"/> Grief / sadness</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Allergies / asthma</p> <p><input type="checkbox"/> Weak immune system</p> <p><input type="checkbox"/> Alternate fever / chills</p>	<p>Spleen</p> <p><input type="checkbox"/> Heaviness in the head / body</p> <p><input type="checkbox"/> Fatigue after eating</p> <p><input type="checkbox"/> Difficult getting up in morning</p> <p><input type="checkbox"/> Water retention</p> <p><input type="checkbox"/> Muscular tired / weak</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Unusual bleeding (stool, nose, etc.)</p> <p><input type="checkbox"/> Bad breath</p> <p><input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> Increased appetite</p> <p><input type="checkbox"/> Crave sweets</p> <p><input type="checkbox"/> Poor digestion</p> <p><input type="checkbox"/> Nausea / vomiting</p> <p><input type="checkbox"/> Bloating / gas</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Loose stool</p> <p><input type="checkbox"/> Alternate constipation / loose</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Intestinal pain / cramping</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Pensive / over-thinking</p> <p><input type="checkbox"/> Overweight</p> <p><input type="checkbox"/> Foggy mind</p> <p><input type="checkbox"/> Yeast infection</p> <p><input type="checkbox"/> Aversion to cold</p> <p><input type="checkbox"/> Cold nose</p> <p><input type="checkbox"/> Increased thirst</p> <p><input type="checkbox"/> Prefer warm / cold drinks</p> <p><input type="checkbox"/> Sweat easily</p>

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.)? _____

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: _____

Menstruation:

Date last menses began: _____ Is your menstrual cycle: Regular _____ Irregular _____

How old were you when you had your first menstruation? _____

How many days of flow? _____ Total 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 ___ At which point during the cycle? Start ___ Mid ___ End _____

Describe the color of your flow: (red, dark red, brown, purple, brownish red, bright red, pink, etc.) _____

Do you experience menstrual pain? Yes ___ No ___ Pain occurs: Before menses ___ During ___ After _____

Stabbing ___ Cramping ___ Dull ___ Heavy ___ What relieves the pain? _____

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 ___ Other symptoms: _____

Ovulation: 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 ___

Pregnancy History:

How many times have you been pregnant? _____ How many times have you given birth? _____

Ages of children _____ 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? _____

<p>Have you ever been diagnosed with:</p> <p>STD? Yes ___ No ___</p> <p>Pelvic inflammatory disease? Yes ___ No ___</p> <p>Uterine fibroids? Yes ___ No ___</p> <p>Polyps? Yes ___ No ___</p> <p>Pelvic adhesions? Yes ___ No ___</p> <p>Prolapsed uterus? Yes ___ No ___</p> <p>Unique shape of uterus? Yes ___ No ___</p> <p>Endometriosis? Yes ___ No ___</p> <p>PCOS (polycystic ovarian syndrome)? Yes ___ No ___</p>	<p>Date of last pap smear: ___ / ___ / ___ (dd/mm/yyyy)</p> <p>Have you ever had an abnormal pap smear? Yes ___ No ___</p> <p>Have you ever had a cervical biopsy or operation? Yes ___ No ___</p> <p>Do you get yeast infections regularly? Yes ___ No ___</p> <p>Do you get bladder infections regularly? Yes ___ No ___</p> <p>If answered yes, list STDs: _____</p>
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<p>Do you experience vaginal discharge? Yes ___ No ___</p> <p>If yes, what color?</p> <p>White ___ Yellow ___ Green ___ Pinkish ___ Red ___</p> <p>If yes, what consistency?</p> <p>Watery/thin ___ Thick ___ Sticky ___</p> <p>If yes, does it have foul odor? Yes ___ No ___</p>	<p>Have you taken oral contraceptives? Yes ___ No ___</p> <p>If yes, for how long? _____</p> <p>When did you stop? _____</p> <p>Have you ever had an IUD? Yes ___ No ___</p> <p>Have you ever taken Depo-Provera? Yes ___ No ___</p>
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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 – *e.g.*, 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

Madison Acupuncture & Complementary Medicine, LLC

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: _____