New Body Acupuncture

240 S. La Cienega Blvd Suite 104
Beverly Hills, CA 90211

Phone: 310-358-0276
Fax: 310-359-1464
www.igetnewbody.com

The Fertility & Hormones Care

First Name	Last Name	Middle Name
Email	Date of Birth(mm/dd/yyyy)	Sex: M F
Cell Phone	SSN	Occupation
Name of Spouse	Cell phone of Spouse	
Home Address (Street Number and Name)		
City	State	Zip Code
Work Address (Street Number and Name)		
City	State	Zip Code
Emergency Contact Person		
Name	Relationship	Phone
Name	Relationship	Phone
Chief Complaint		
1:		
2:		
3:		
4:		

Marital Status (Circle one): Married ___ years Widowed Divorced Single Separated Partnership

Medication List:

1:_____ 2:_____

3:_____ 4:_____

How did you know *New Body Acupuncture*?

Yelp, Google, Ads or Friend(name): _____ Phone # ( )

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History (List your important medical history, When and How long):

Medical Problems	Mark(x)	How long	Medical problems	Mark(x)	How long

Family History (List your important family medical history, Allergies, Clotting Problem, Diabetes, Cancer and other)

You	Father	Mother	Siblings	Spouse

Male Only(Semen Analysis)

Sperm Count:		*Sperm Volume:*	
Sperm Concentration million per ml:		*Total Motility (Progressive and non-p) %:*	
Progressive Motility %:		*Sperm Concentration million per ml:*	
Morphology %:		*Testosterone:*	

Female Only *(Circle the Main Reason for which You Are Seeing the Acupuncturist)*

	Abnormal Pap Smear		*Abnormal Discharge*		*HPV*		*Candida*
	Irregular Bleeding		*Menopause*		*PCOS*		*PMS, PMDD*
	Diminished Ovarian Reserve		*POF (Premature Ovarian Failure)*		*Freeze Eggs*		*Egg Retrieval or Post*
	IUI Failure		*IVF Failure*		*Infertility*		*Chromosome Infertility*
	Unexplained Infertility		*RIF(Repeated Implantation Failure)*		*Miscarriage*		
	Hormone Problems		*FSH:*		*AMH:*		*Estrogen:*
	Progesterone:		*LH:*		*Testosterone:*		*TSH:*
	Prolactin:		*DHEA:*		*HCG:*		*Other:*

Your Fertility Dr.	*Name:*	*Phone:*
Address		
Your OB/GYN:	*Name:*	*Phone:*
Address		

Menstrual Cycle*: First day of last cycle: _____ Cycle lasts _____ days. How often per cycle: _____ days.*

Do you bleed between cycles? Yes _____days ? No; Pregnancy now? YES _____Months? NO. Method of birth control: _____

Pregnancy-related problems: _____

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Informed Consent

I, the undersigned, hereby authorize **Dan Wu**, L.Ac, MD(P.R.China), Who received his master's degree in Traditional Chinese Medicine and MD. And who is currently licensed in the state of California (Lic#12026), to perform the following acupuncture procedures:

Acupuncture: The insertion of sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.
Cupping: A technique used to relieve symptoms by applying cups made of glass to the with a vacuum created by heat. This may create bruising or temporary skin discoloration.
Moxabustion: The burning of herbs on or near the body to warm it, strengthen it, and relieve symptoms. Moxa comes in several forms, such as a stick, cone, or ball.
Oriental bodywork (tuina): An ancient technique of Chinese medical massage.
Herbs Tea: Food and herbal advice based on Traditional Chinese Medical Theory.
Electro-Acupuncture: The running of a low electrical current through one or more needles to help heal the body.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: Although uncommon, there is a potential for acupuncture to produce some discomfort or pain at needled sites, minor bruising, or infection. It may also cause temporary tingling, dizziness, and lightheadedness, a broken needle, temporary discoloration of the skin, and potentially an aggravation of symptoms existing prior to the acupuncture treatment. Clients with severe bleeding disorders or pace-makers should inform the acupuncturist prior to treatment.

Potential benefits: Drug-free or drug-reduced relief of presenting symptoms and the improved balance of bodily energies which may lead to prevention or elimination of the client's complaint(s).

Please initial the following five statements

____ **Initial**: I understand that this treatment will be performed by an acupuncturist licensed in the state of California. The acupuncturist is trained in the field of Oriental Healing Arts and is not making a medical diagnosis of a disease or medical condition. I understand that a medical condition can only be diagnosed and advised upon by a licensed physician.

____ **Initial**: I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and 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 known facts, is in my best interest.

____ **Initial**: All my records will be kept confidential and will not be released without my written consent but may be reviewed by the clinical and administrative staff at this office. I have read or had read to me the above consent and by signing below I agree to the above named procedures, and intend this consent to cover my entire courses of treatment for the present or future conditions for which I seek treatment.

____ **Initial**: I hereby release Dan Wu, L.Ac.,from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand I am free to withdraw my consent and to discontinue participating in these procedures at any time.

____ **Initial**: Your appointment is a time set aside for you and the acupuncturist. In order to ensure each patient's time is respected, please cancel with less than 24 hours notice. We appreciate your appreciate your consideration and your understanding that others may be waiting for the appointment you miss.

Patient's Name (printed)_____ Date(mm/dd/yyyy)_____

Patient's Signature_____

Signature of Legal Guardian (if patient is underage)_____ Date(mm/dd/yyyy)_____