Patient Information Sheet
Fertility

Name: ____ Date _____________________

Home
Street____

City, State, Zip ____

Home Phone ____ Cell Phone _______________________________

Email ____ Birth date _______________________________

Work
Address ____

City, State, Zip ____

Phone____ Email ____________________________________

Emergency
Physician Name and Phone number ____

Person(s) to contact in case of an emergency ____

Address & Phone Number____

Medications and Supplements
Please list any medications and supplements you are currently taking, including vitamins.

____

____

____

____

Areas of Main Concern
Please list your areas of main concern in order of priority (get detailed). Use the back of the page if necessary.

1. ____

2.____

3.____

How did you hear about Shams Wesley? ____

Health History

Mark an X in the box for any of the following that apply.

	You	Father	Mother	Siblings	Spouse
Allergies/Asthma					
Anemia					
Clotting problems					
Diabetes					
Cancer or tumor					
Epilepsy					
Genetic disease					
Smoking cigarettes					
Alcohol or drug addiction					
Nervous breakdown					
Rheumatism or arthritis					
High blood pressure					
Heart trouble					
High cholesterol					

Circle any of the following that you now have or have ever had.

Eye Disease/Infection
Thyroid disease
Eczema, Hives, etc.
Hernia
Drug abuse
Autoimmune Disease
Mononucleosis
Hepatitis (any)
Obesity
STD

Pneumonia
Pancreatitis
Liver disease
Hyperactivity
Osteoporosis/penia
Ulcerative Colitis
Chrones Disease
Yeast Overgrowth
Steroid Use
Leaky Gut

Neuralgia/Neuritis
Blood-Borne Diseases
Blood transfusion
Polio
Rheumatic fever
Malaria
Eating Disorder
Sit at a Computer a lot
Diverticulitis

Scarlet fever
Measles
Mumps
Yellow jaundice
Tuberculosis
Bronchitis
Chicken pox
German measles
Parasites

Hospitalizations

	Year	Operation or Illness
1st Hospitalization		
2nd Hospitalization		
3rd Hospitalization		

Check the appropriate box for any of the following that you now have or have ever had.

Women

	Current problem	Past problem	Never a problem		Current problem	Past problem	Never a problem
Yeast Infections				Breast lumps			
Tubal ligation				Fibroid tumors			
Pelvic Inflammatory Disease (PID)				Abnormal vaginal or anal PAP smear			
Abnormal mammogram				Abnormal vaginal bleeding			
Perimenopause				Trichomonas			
Menopause				Syphilis			
Infertility				HIV / AIDS			
Hair loss				Herpes			
Chemotherapy				Chlamydia			
Radiation treatment				Vaginal discharge			

Please list the details of any ART (artificial reproductive therapy). Use back of sheet if needed.

	How many?	Dates	Name and dose of meds taken	Result	What was recommended next?
IUI (insemination)					
IVF (in vitro fertilization)					
Medication only					

Cause of infertility (if that is why you are seeking treatment) (circle answers)

Amenorrhea	Not ovulating	PCOS	Endometriosis
Poor egg quality	Over or underweight	Genetic factors	Unknown causes
Luteal phase too long or short	Blocked fallopian tubes	Past Chemotherapy/ Radiation	Anti-sperm antibodies
Low FSH, estrogen or progesterone	Follicular phase too long or short	Problem not listed	Excessive alcohol consumption

Check the appropriate box for any of the following that you now have or have ever had.

Men

	Current problem	Past problem	Never a problem		Current problem	Past problem	Never a problem
Loss of Libido				Low testosterone			
Varicole				Low DHEA			
Low sperm count				Low LH			
Poor sperm motility				Low FSH			
Poor morphology				Low cortisol			
Sperm antibodies				Syphilis			
Injured penis/scrotum				HIV / AIDS			
Breast lumps				Herpes			
Chemotherapy				Chlamydia			
Radiation treatment				HPV			
Testicular swelling, lumps or pain				Gonorrhea			
Itchy, painful, red or swollen genitals				Prostate trouble			
Burning or discharge from penis				Urinary difficulties			

Circle Yes or No

Can you regularly achieve an erection and maintain it long enough to ejaculate?	Yes	No
Are your erections as hard as they used to be?	Yes	No
Do you ever have difficulty ejaculating or find yourself unable to ejaculate at all?	Yes	No
Do you ever have pain upon ejaculation?	Yes	No
Do you ever ejaculate prematurely?	Yes	No
Have you been on any medications for erectile dysfunction? If so, please describe.	Yes	No
Have you ever had a vasectomy reversed?	Yes	No

Please list the approximate dates and results of your last 3 sperm tests:

____

____

____

Health History

If a symptom is from pregnancy or trying to become pregnant, write "P" in the box next to it.
If a symptom is long-term or not pregnancy-related, put a CHECK in the box next to it.

	Often feel tired
	At times have a weak appetite for food
	At times have loose and/or watery stools
	At times have undigested food in your stools
	Often belch after eating or drinking
	At times have difficulty swallowing
	At times have intestine/stomach pain or gurgling
	At times feel bloated after eating or drinking
	At times feel nauseous
	At times have mucusy or sticky stools
	At times have heavy limbs or head
	Gained/lost more than 10 lbs in last 6 months
	Traveled outside the US in the last 6 months
	Have lumps or swellings anywhere
	At times have stuffy nose/sinuses when not sick
	At times have food sit in your stomach like a rock
	Experience frequent hunger
	At times feel unsatisfied after you eat
	At times have heartburn or reflux
	Prefer cold liquids
	At times have swelling, bleeding, or painful gums
	Prefer warm foods and liquids
	Have any skin problems
	Tend to have dry skin
	Tend to have oily skin
	At times have itchy or burning skin
	At times have nosebleeds when the heat is on
	At times have hoarse voice or voice loss
	At times feel sensitive to contact irritants
	Ever experience irregular breathing
	At times feel short of breath
	Tend to catch whatever is going around
	Feel susceptible to drafts
	Have coughing bouts or wheezing
	Tend to run cold

	At times have swelling in your legs, ankles or feet
	Generally have clear-colored urine
	Ever have diarrhea in the a.m., soon after waking
	Have a weak, tired or achy back or knees
	Experience low libido
	Tend to run hot
	Ever have difficulty sitting still/feel restless
	At times feel dry and dehydrated
	At times have very yellow urine
	Ever sweat at night
	Ever feel hot in the afternoon
	Have a brittle or tight back or knees
	Notice your hearing has been getting worse
	Ever hear a low or dull ringing in your ears
	Have a fertility problem
	Have partially/fully white hair
	Have partial or full balding
	Have a history of ever having significant hair loss
	Urinate more than 6-7 times a day
	Experience incontinence, bedwetting, dribbling
	Suffer from frequent and/or urgent urination
	Ever find it difficult to start the flow of urine
	Ever have a weak or slow urine stream
	Ever experience pain or burning with urination
	Ever have blood in your urine
	Ever have cloudy urine
	Ever have Kidney or Gall Bladder stones
	Drink at least four 8 oz glasses of water a day
	Drink more than 16 oz. of coffee, tea or soda daily
	Notice any body part always feels numb/odd
	If yes, where ___________________________
	Ever get dizzy upon standing
	At times have muscle cramps or spasms

Health History

If a symptom is from pregnancy or trying to become pregnant, write "P" in the box next to it.
If a symptom is long-term or not pregnancy-related, put a CHECK in the box next to it.

	Ever have blurry vision
	Ever seen floaters
	At times have dry eyes
	Have dry, weak, ridged or brittle fingernails
	Ever have tightness, pressure in ribs or chest
	Ever have a feeling of a lump in your throat
	At times have a tight neck and/or shoulders
	At times get tension headaches
	At times feel troubled by gas
	At times feel constipated
	Have you been diagnosed with hypertension
	Have you ever had high cholesterol
	Have a fiery temper
	Imbibe one or more alcoholic drinks a day
	Ever used illegal drugs
	Regularly use sleeping pills, pain killers, etc.
	Ever have a sudden or urgent need to pass a b.m.
	Notice your stools at times have a very bad odor
	Ever feel a burning or itching around your anus
	At times have twitching muscles, tics or tremors
	Have you ever fainted or lost consciousness
	Have you ever had convulsions or a seizure
	Ever notice your own heartbeat
	Wake up several times during the night
	Often feel anxious, nervous or uneasy
	Often forget things (like where your car keys are)
	Startle easily, feel jumpy or unsettled
	Ever get tongue/mouth canker sores, ulcerations
	Ever toss and turn all night, feeling hot/agitated
	Have Attention Deficit Disorder or ADHD
	Have trouble focusing or get distracted easily
	Tend to be shy or sensitive
	Feel lonely or sad

	Feel as if you're carrying a large burden
	Feel clingy or needy
	Tend to feel isolated
	Carry a lot of grief or regret
	Have difficulty relaxing
	Spend most of your time working
	Feel troubled by frightening dreams or thoughts
	Often feel overwhelmed
	Have a hopeless outlook
	Find it hard to make decisions
	Have a fixed or stabbing pain anywhere
	Have scar tissue from injuries or surgeries
	Have a history of masses or tumors
	Have times in your life you cannot remember
	Have pain or soreness in muscles, tendons, joints
	Does this pain fluctuate with weather changes
	Is the pain fixed
	Is there local swelling

Health History

If a symptom is from pregnancy or trying to become pregnant, write "P" in the box next to it.
If a symptom is long-term or not pregnancy-related, put a CHECK in the box next to it.

	Women's Health
	Had atypical periods recently?
	Are you pregnant or in menopause (circle one)
	Had a hysterectomy
	Menstruate on an irregular schedule (generally)
	Have your periods ever stopped (other than during pregnancy, breastfeeding or menopause)
	Have pain with your menses or at ovulation
	Have extreme pain with menses or at ovulation
	Have tender, sore breasts before menses
	Feel bloated before your menses or at ovulation
	Have heavy bleeding with your menses
	Ever notice your menstrual blood is bright red
	Ever have itchy, painful, red or swollen genitals
	Any recent vaginal itching or discharge
	Often have very dark menstrual blood
	Often have clots in your menstrual blood
	Have a history of birth control complications
	Have you ever had an abortion
	Ever had a fibroid or breast lump (circle one)
	Ever bleed after intercourse or between periods
	Have uterine or vaginal prolapse
	Get regular PAP smears and/or mammorgrams
	_________ Number of pregnancies
	_________ Number of children born alive
	_________ Number of premature births
	_________ Number of miscarriages
	_________ Number of terminated pregnancies
	Please list the approximate dates of prior pregnancies
	_______________ _______________
	_______________ _______________
	_______________ _______________

	Check off the pregnancy symptoms you have now or have had in the past	
Now	Past	
		Nausea
		Heartburn
		Breast tenderness
		Fatigue
		Extreme fatigue
		Frequent urination
		Dizziness/fainting
		Food cravings or aversions
		Constipation
		Mood swings/crying/irritability
		Feeling of heat beyond the norm
		Vaginal bleeding
		Low back pain
		Feeling bloated
		Extreme hunger
		No appetite
		Insomnia
		Pubic bone pain
		Leg cramps
		Darkening skin
		Constipation
		Excessive weight gain
		Pre-eclampsia
		Swelling
		Shortness of breath
		Varicose veins or hemorrhoids
		Braxton Hicks contractions
		Breech presentation
		Were you ever put on bed rest?
		Have you ever given birth prematurely?

Please list any other pertinent information about your particular situation. Use the back if you need to. Thanks!

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Informed Consent

I, the undersigned, hereby request that Shams Deckter Wesley, L.Ac., M.Ac., and/or other licensed acupuncturists who now or in the future treat me while employed by, working/associated with, or serving as back-up for Shams Deckter Wesley, including those working at the clinic or office referred to below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), Shiatsu (acupressure), Chinese herbal medicine and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, dizziness or fainting, 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. Bruising is a common side effect of cupping. Unusual risks of acupuncture include: nerve damage and organ puncture, including lung puncture (pneumothorax), and spontaneous miscarriage. Infection is another possible risk, although the clinic uses sterile, disposable needles one time only and maintains a clean and safe environment.

Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes risks of treatment, other side effect and risks may occur. 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, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

_____Initial: 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 course of treatment for the present or future conditions for which I seek treatment.

_____Initial: I understand that an acupuncturist licensed in the state of Georgia will perform this treatment. 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 they may be reviewed by the clinical and administrative staff at this office.

_____Initial: I hereby release Shams Deckter Wesley, M.Ac., L.Ac. and any practitioner I receive treatment from in this office from all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care.

_____Initial: Your appointment is a time set aside for you and the acupuncturist. In order to ensure each patient's time is respected, ***a $25 charge may be applied to missed appointments or cancellations with less than 12 hours notice.*** We appreciate your consideration and your understanding that others may be waiting for the appointment you miss.

Patient's Name (printed): ____ Date____________________

Patient's Signature: ____

Signature of Legal Guardian (if patient is underage):____

Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn, at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with, serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office, whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages,

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the Sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or. (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here _______ This agreement is effective as of the date of first professional services. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient's Name (printed):____

Patient's Signature:____

Signature of Legal Guardian (if patient is underage): ____