Tel: (858) 495-0771
Fax: (858) 495-0772
www.ZenFertility.com
Info@ZenFertility.com

Welcome! We are pleased to welcome you to Zen Fertility Center and thank you for choosing our clinic to partner with you in achieving your health goals.

On the following pages, you will find questions designed to provide vital information which is necessary to individualize a program specific to your health goals. This individualization of the treatments is one of the strong points of Chinese Medicine. It is why people may experience broad changes within themselves after receiving acupuncture for a specific complaint. Complete the entire questionnaire thoroughly prior to your first session and bring it with you. Some of the questions may seem unrelated to your complaint, but they may play a major role in diagnosis and treatment. *All information is strictly confidential.*

NEW PATIENT INFORMATION

Attire for Acupuncture Patients

Please wear loose, comfortable clothing. Gowns and sheets are available if you are wearing clothing that prevents access to areas of the body that need to be treated. Draping will be provided to ensure modesty. In consideration of others, please refrain from wearing perfume/cologne, strongly scented oils or lotions. For your safety and comfort, please turn off cell phones and pagers prior to your treatment.

Needles

Only sterile, disposable needles are used.

What To Expect On Your First Visit

- Allow yourself 1.5 hours for your first treatment (2 hours if you and your significant other are being evaluated together) and 1 hour for follow-up visits.
- Always eat before you come for treatment. You should not have acupuncture when you are hungry.
- Once escorted into a treatment room, the Doctor will begin your evaluation by asking you many questions. In addition, the Doctor may take your pulse, look at your tongue, palpate specific points, or check your range of motion.
- Upon conclusion of your first visit, the Doctor will make a treatment recommendation. This will include frequency of treatment and possibly herbal medicine, supplements, nutritional and lifestyle changes, or refer you to another healthcare provider. Please take these suggestions seriously as they are based on years of experience as well as your individual circumstances. Because they augment the effects of acupuncture, implementing the herbs and supplements (if recommended) and other suggested changes will help you to respond more quickly and achieve the desired results sooner.
- Please utilize this time to ask any questions that you may have.

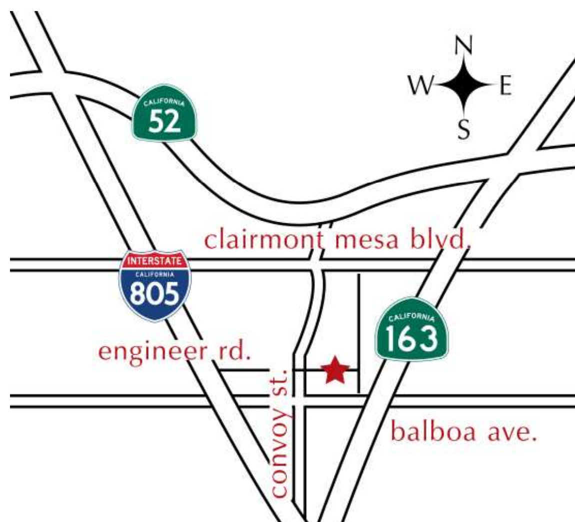
What To Expect AFTER Your First Visit

- After the treatment, the most common feeling is being relaxed but some people feel energized. Take a few minutes to rest and drink some water.
- Note how you feel, physically, mentally, and emotionally until the next treatment. Please inform your Doctor of any changes at your next visit so your treatment can be modified if necessary.
- On rare occasions one's original symptoms may briefly get worse after the first treatment. A flare-up typically occurs later on the day of your treatment for a few hours and then improvement and relief follow. In the long run, acupuncture does not make symptoms worse.

- After the treatment, please do not exercise vigorously for the rest of the day. A mild walk is fine.
- Please avoid exposure to extreme hot or cold temperature after the treatment.
- If you have any additional questions or concerns after your treatment, please do not hesitate to telephone or email us.

Our Policies

- Payment must be in cash, Visa, or Mastercard.
- Unlike other medical offices, we do not double book so your appointment time is reserved only for you. As a courtesy to your practitioner, please provide at least 24 hours notice of cancellation to avoid being assessed the full treatment fee. If you must change your appointment within 24 hours of your appointment due to unforeseen emergencies, please call us. **Do not email with less than 24 hours notice as we may not receive the email in time to make timely changes.**
- Call if you will be more than 15 minutes late as we may need to reschedule.
- Communication via email should be reserved for non-urgent matters. By law, we are not allowed to give medical advice via email or phone without an office visit.
- Equal care will be provided to all patients regardless of age, race, ethnicity, physical ability, religion, sexual orientation or gender identity/expression.



Zen Fertility Center
7969 Engineer Road, Suite 209
San Diego, CA 92111
(858) 495-0771

Parking

If street parking is not available, look for the Chang Acupuncture signs (our previous name) above parking spaces #209 (our suite) and #210 on the right hand side of the building's parking lot or if those are taken, park anywhere on the left hand side of the lot.

Patient Information Sheet

CONFIDENTIAL

San Diego & Encinitas ☯ Phone: (858) 495-0771 ☯ Fax: (858) 495-0772 ☯ www.ZenFertility.com

Complete this form as thoroughly as possible. Some questions may seem unrelated to your condition but they may affect your diagnosis and treatment. All information is confidential.

Date	Full Name			Preferred Name/Nickname
Gender M F	Date of Birth	Age	Marital Status Married Single Domestic Partner Separated Divorced	
Address		City	State	Zip
Daytime Phone # (home, work, cell – circle one) ( )	Cell Phone # (home, work, cell – circle one) ( )			
If you would like to receive appointment reminders via text message, circle your wireless provider. Standard text messaging rates may apply. AT&T Cricket Sprint T-Mobile Verizon Other ______________________				
Emergency Contact & Relationship	Phone Numbers of Emergency Contact Primary ( ) Alternate ( )			
Email: ____ Your email will be used to send appointment confirmations and for internal purposes only. We hate spam too so will guard your privacy.				
Primary Care Physician	Specialty			
Other Doctors You See	Specialty			
Other Doctors You See	Specialty			
How did you hear about us?				
Why did you chose Zen Fertility Center?				
Cancellation Policy – I acknowledge that I will give at least 24 hour notice of cancellation to avoid a charge for the session. This is a courtesy to other patients who may need that appointment time. I will call if I anticipate being more than 15 minutes late for my appointment. Initials _________				

Major Complaint(s), in order of importance to you:

	Severe	Moderate	Slight	
1.	☐	☐	☐	______________________________
2.	☐	☐	☐	______________________________
3.	☐	☐	☐	______________________________

Name____

FAMILY HISTORY		MEDICAL CONDITIONS **Please list conditions you have or have had and year diagnosed.**		
Relation	Medical Conditions	Year	Condition	Surgery Needed?
Father				
Mother				
Siblings				
Partner				
Children				

HEALTH HABITS Check (✓) all that apply & describe how much.		**ALLERGIES** Medications, Seasonal, Environmental, Food	**OCCUPATIONAL CONCERNS** Check (✓) if your work exposes you to the following.
☐ Caffeine			☐ Stress
☐ Tobacco			☐ Heavy Typing/Computer Use
☐ Alcohol			☐ Hazardous Substances
☐ Sugar			☐ Heavy Lifting
☐ Drugs			☐ Other
☐ Other			
			Occupation:

MEDICATIONS & SUPPLEMENTS
Please list all prescription medication, over-the-counter products, vitamins, supplements, herbs, homeopathics and any other products. Remember inhalers, eye drops, nose drops.

Name	Purpose	How long	Dose	How often	Last Dose

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at this office or any other office or clinic, whether signatories to this form or not.

I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal 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 immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all 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 at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the office medical and administrative staff 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, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, 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 for any future condition(s) for which I seek treatment.

Patient's Name ____________________________________

Patient's Signature___________________________________ Date Signed __________________

To be completed by the patient's representative if the patient is a minor or is physically or legally incapacitated:

Print Name of Patient ____

Print Name of Patient Representative _____________________________________

Signature of Patient Representative _______________________________________

Relationship or Authority of Patient _______________________________________

Policy for Keeping Appointments

We understand that unforeseen circumstances may prevent you from making your appointment. However, please make every effort to give us as much notice as possible for any cancellations so we can offer it to another client. We are committed to providing you with the best care possible. In return, we ask the same commitment from you by attending your scheduled appointments, otherwise you will not obtain the benefits that you are seeking.

We also ask that you make every effort to arrive on time to your scheduled appointment time. If you are running late, please telephone the office as we may have to reschedule your appointment if we cannot accommodate you.

____________________________________ ________________________
Signature of Patient or Responsible Party Date

Payment of Services Rendered

Payment is due at the time services are rendered. Cash, Visa, and Mastercard are accepted. Returned checks will incur a $25 fee.

____________________________________ __ ______________________
Signature of Patient or Responsible Party Date

Release of Information

In order to facilitate care at a specialist's office and at your request, Zen Fertility Center may release information regarding your medical condition and treatment, address, phone number. I agree to the release of this information.

____________________________________ ________________________
Signature of Patient or Responsible Party Date

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been offered a copy of this office's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that any amended Notice of Privacy Practices will be available at each appointment.

____________________________________ ________________________
Signature of Patient or Responsible Party Date