

Welcome to the office of Dr. Alison Hunter L.Ac.,O.M.D
1314 Lincoln Ave. Suite 2F
San Jose, CA 95125
831 239 2623

Please provide us with some information about yourself and your health conditions so that we may do our best to treat you. We consider this information privileged physician/patient communication and will hold it in confidence.

Patient Information

NAME (LAST, FIRST, MIDDLE)			DATE	
AGE	DATE OF BIRTH	SEX _ Male _ Female	MARITAL STATUS _ Single _ Married _ Separated _ Divorced _ Widowed	
HOME ADDRESS		CITY	STATE	ZIP
PHONE – HOME		CELL	EMAIL ADDRESS	
EMPLOYED BY				
EMPLOYERS ADDRESS		CITY	STATE	
OCCUPATION		WORK PHONE		
SPOUSE'S NAME				
CONTACT IN CASE OF AN EMERGENCY		RELATIONSHIP	PHONE	
MEDICAL INSURANCE CARRIER		POLICY NUMBER	SOCIAL SECURITY NO.	
HOW DID YOU HEAR ABOUT OUR CLINIC?				
NAME OF YOUR OB-GYN DOCTOR		NAME OF YOUR FERTILITY OR REPRODUCTIVE CLINIC		

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Medical History

MAJOR COMPLAINT/HEALTH PROBLEM YOU WOULD LIKE US TO TREAT:

HOW DID THIS CONDITION DEVELOP?

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC.)

HOW LONG HAS THIS CONDITION PERSISTED?

IS THERE ANYTHING THAT MAKES IT BETTER OR WORSE?

IF YOU HAVE PAIN—IS IT SHARP OR SHOOTING, PINS AND NEEDLES, OR DULL? CHRONIC OR ACUTE?

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LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO:

LIST ANY MEDICATIONS/HERBS/DRUGS THAT YOU ARE CURRENTLY TAKING:

LIST ANY MAJOR SURGERIES YOU HAVE HAD:

Do you have a history of any of the following conditions?

AIDS	Yes	No	High Blood Pressure	Yes	No
Anxiety Attacks	Yes	No	Intestinal Bleeding	Yes	No
Asthma	Yes	No	Kidney Infection	Yes	No
Autoimmune Disease	Yes	No	Kidney Stones	Yes	No
Birth Defects	Yes	No	Lupus Erythematosus	Yes	No
Bladder Infections	Yes	No	Migraine	Yes	No
Blood Disorders	Yes	No	Neurologic Disorders	Yes	No
Breast Tumors or Cancer	Yes	No	Other Forms of Arthritis	Yes	No
Bronchitis	Yes	No	Other Heart Conditions	Yes	No
Cancer	Yes	No	Other Kidney Problems	Yes	No
Cirrhosis	Yes	No	Other Lung Problems	Yes	No
Connective Tissue Disorders	Yes	No	Panic Attacks	Yes	No
Diabetes	Yes	No	Paralysis	Yes	No
Epilepsy	Yes	No	Pneumonia	Yes	No
Gallstones	Yes	No	Prolonged Dizziness	Yes	No
Gastric/Duodenal Ulcers	Yes	No	Rheumatic Fever	Yes	No
German Measles (Rubella)	Yes	No	Rheumatoid Arthritis	Yes	No
Glasses/Contact lenses	Yes	No	Seizures	Yes	No
Heart Attack	Yes	No	Thyroid Problems	Yes	No
Heart Disease	Yes	No	Tuberculosis	Yes	No
Heart Murmur	Yes	No	Varicose Veins	Yes	No
Hepatitis	Yes	No			

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Health History

Please check any symptoms you currently have or have had in the past year:

General	<input type="checkbox"/> Difficulty inhaling	<input type="checkbox"/> Overweight	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Chills	<input type="checkbox"/> Difficulty exhaling	<input type="checkbox"/> Very overweight	<input type="checkbox"/> Handwriting change
<input type="checkbox"/> Low energy	Cardiovascular	Genitourinary	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Dilute urine	<input type="checkbox"/> Stroke
<input type="checkbox"/> Allergies	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Dark urine	<input type="checkbox"/> Seizures
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Tremor
<input type="checkbox"/> Fevers	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Cloudy urine	<input type="checkbox"/> Recent clumsiness
<input type="checkbox"/> Excess thirst	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Burning urination	<input type="checkbox"/> Drowsiness
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Scanty urine	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Profuse urine	Emotional
<input type="checkbox"/> Numbness	<input type="checkbox"/> Hypochondriac pain	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Sweat spontaneously	<input type="checkbox"/> Distention in chest or hypochondrium	<input type="checkbox"/> Poor bladder control	<input type="checkbox"/> Irritability
<input type="checkbox"/> Night sweating		<input type="checkbox"/> Urgency to urinate	<input type="checkbox"/> Often feel angry
<input type="checkbox"/> Lack of sweating			<input type="checkbox"/> Troubling dreams
<input type="checkbox"/> Weight loss	Gastrointestinal	Musculoskeletal	<input type="checkbox"/> Cry uncontrollably
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Abdominal pain	Pain, weakness, numbness:	<input type="checkbox"/> Feel sad a lot
<input type="checkbox"/> Aversion to heat	<input type="checkbox"/> Bloating	<input type="checkbox"/> Arms	<input type="checkbox"/> Forgetful
<input type="checkbox"/> Aversion to cold	<input type="checkbox"/> Belching	<input type="checkbox"/> Feet	<input type="checkbox"/> Mind not clear
Head & Neck	<input type="checkbox"/> Gas	<input type="checkbox"/> Hands	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Constipation	<input type="checkbox"/> Joints	<input type="checkbox"/> Much fear
<input type="checkbox"/> Heaviness in the head	<input type="checkbox"/> Diarrhea/loose stools	<input type="checkbox"/> Legs	<input type="checkbox"/> Unrestrained joy
<input type="checkbox"/> Headache	<input type="checkbox"/> Bloody stools	<input type="checkbox"/> Hips	<input type="checkbox"/> Terrors
<input type="checkbox"/> Phlegm in throat	<input type="checkbox"/> Black stools	<input type="checkbox"/> Neck	<input type="checkbox"/> Difficulty expressing emotions
<input type="checkbox"/> Cataract	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Shoulders	
<input type="checkbox"/> Double vision	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Pain all over	Men Only
<input type="checkbox"/> Earache	<input type="checkbox"/> Heartburn/reflux	<input type="checkbox"/> Cold limbs	<input type="checkbox"/> Genital pain
<input type="checkbox"/> Ear discharge	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Knee problems	<input type="checkbox"/> Impotence
<input type="checkbox"/> Eye pain/strain	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Genital sores
<input type="checkbox"/> Corrected vision	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> All over weakness	<input type="checkbox"/> Lump in testicles
<input type="checkbox"/> Nasal obstruction	<input type="checkbox"/> Stomachache	<input type="checkbox"/> Lack of strength	<input type="checkbox"/> Penis discharge
<input type="checkbox"/> Nasal discharge	<input type="checkbox"/> Nausea	<input type="checkbox"/> Broken bones	<input type="checkbox"/> Nocturnal emission
<input type="checkbox"/> Loss of sense of smell	<input type="checkbox"/> Vomiting	Skin	<input type="checkbox"/> Low sexual energy
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Thick skin	Women Only
<input type="checkbox"/> Hoarseness	Diet/Lifestyle	<input type="checkbox"/> Thin skin	<input type="checkbox"/> Abnormal pap smear
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Vegetarian	<input type="checkbox"/> Broken blood vessels	<input type="checkbox"/> Bleed between periods
<input type="checkbox"/> Recurrent sore throat	<input type="checkbox"/> Healthy diet	<input type="checkbox"/> Blood not clotting	<input type="checkbox"/> Irregular periods
<input type="checkbox"/> Red/inflamed eye	<input type="checkbox"/> Eat much fried foods	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Heavy periods
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Eat much meat	<input type="checkbox"/> Discoloration	<input type="checkbox"/> <25 day cycle
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Smoke cigarettes	<input type="checkbox"/> Dark circles around eyes	<input type="checkbox"/> >35 day cycle
<input type="checkbox"/> Sores on lips	<input type="checkbox"/> Drink alcohol	<input type="checkbox"/> Bags under eyes	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Sores on tongue	<input type="checkbox"/> Drink coffee	<input type="checkbox"/> Lumps in groin	<input type="checkbox"/> Painful periods
<input type="checkbox"/> Taste change	<input type="checkbox"/> Use drugs	<input type="checkbox"/> Lumps underarm	<input type="checkbox"/> Premenstrual tension
<input type="checkbox"/> Teeth problems	<input type="checkbox"/> Eat a lot of sweets	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Breast lumps
<input type="checkbox"/> Vision – see halos	<input type="checkbox"/> Take melatonin	<input type="checkbox"/> Acne	<input type="checkbox"/> Contraceptives
Respiratory	<input type="checkbox"/> Take steroids	<input type="checkbox"/> Brittle nails	<input type="checkbox"/> Sores on genitalia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Exercise regularly	<input type="checkbox"/> Premature gray hair	<input type="checkbox"/> Low sexual energy
<input type="checkbox"/> Hay fever	<input type="checkbox"/> Exercise excessively	<input type="checkbox"/> Dry, brittle hair	<input type="checkbox"/> Vaginal discharges
<input type="checkbox"/> Persistent cough		<input type="checkbox"/> Hair falling out	<input type="checkbox"/> Menopausal
<input type="checkbox"/> Coughing blood	Weight	Neurologic	<input type="checkbox"/> Uterine prolapse
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Underweight	<input type="checkbox"/> Fainting	<input type="checkbox"/> Facial hair
<input type="checkbox"/> Recurrent bronchitis	<input type="checkbox"/> Normal for height		<input type="checkbox"/> Loss of head hair
<input type="checkbox"/> Phlegm production			<input type="checkbox"/> May be pregnant

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Age at which menses began _____

Date of last menstrual period _____

Are your periods painful? Yes No Somewhat How many days does the pain last? _____

Are your menstrual cycles spaced irregularly? Yes No

How many days are there from one period to the next? _____

How many days do you normally bleed? _____

How heavy is the bleeding? Light Normal Heavy

What color is the blood? Light red Red Dark red Purple Brown Black

Is there clotting? Yes No Size _____ Color _____

Do you bleed or spot between periods? Yes No

Do your bowel movements become loose at the beginning of you period or just prior to? Yes No

Do you have premenstrual tension? Yes No

Do your breasts become tender premenstrually? Yes No

Do you get premenstrual low back pain? Yes No

Does your face break out before or during your period? Yes No

Number Years

How many pregnancies have you had? _____

How many children do you have? _____

How many abortions have you had? _____

How many miscarriages have you had? _____

How many times has a D&C been performed? _____

Date of last Pap smear _____

Have you ever had an abnormal pap smear? Yes No

Have you ever had a cervical biopsy, operation, cauterization or conization? Yes No

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Have you ever had a venereal disease? (Chlamydia, gonorrhea, syphilis, herpes, other)__ Yes __ No

Have you ever had pelvic inflammatory disease? __ Yes __ No

Were you treated for it? __ Yes __ No

How _____

Do you get yeast infections regularly? __ Yes __ No How do you treat them?

Do you have chronic vaginal discharge? __ Yes __ No

Do you have any sores on your genitalia? __ Yes __ No

Have you ever been diagnosed with uterine fibroids or polyps? __ Yes __ No

Have you ever been diagnosed with endometriosis? __ Yes __ No

Have you ever been diagnosed with pelvic adhesions? __ Yes __ No

Have you been diagnosed with any pelvic abnormalities? __ Yes __ No

Have you taken any medications for gynecological conditions other than contraceptives? __ Yes __ No

Medication	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since they began? __ Yes __ No

How? _____

Do you ovulate on your own? __ Yes __ No

On what day of your cycle? _____

Have you taken medication to help you ovulate? __ Yes __ No

When _____ How long? _____

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Do you get stretchy cervical mucus around ovulation? Yes No

Do your breasts get tender at/during ovulation? Yes No

Do you use a BBT graph to chart your temperature rise and ovulation? Yes No

Have you had fertility treatments? Yes No

If yes, when and where? _____

By whom? _____

What types? _____

Do you know what your FSH level is on Day 3? Yes No

Have your fallopian tubes been evaluated medically? Yes No

What were the results? _____

Have you had any tubal operations? Yes No

Have you had any hormone laboratory tests performed? Yes No

What were the results? _____

Has your partner or spouse had a fertility workup? Yes No

What were the results? _____

Is your partner supportive of your wish to conceive? Yes No

How is your sexual energy? Low Normal High

Do you douche regularly? Yes No

With what? _____

Do you use vaginal lubricants? Yes No

Are you more than 20% over your ideal body weight? Yes No

Are you more than 20% below your ideal body weight? Yes No

Do you have a stressful occupation? Yes No

Do you exercise regularly? Yes No

Do you have excessive facial hair? Yes No

Do you have excessively oily skin? Yes No

Have you experienced excessive loss of head hair? Yes No

Have you noticed discharge from your nipples? Yes No

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Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? Yes No

Have you been exposed to any known environmental toxins or hormones? Yes No

Are you presently taking steroids? Yes No

Any irregular lab results for the thyroid? Yes No

Do you have natural killer cells? Yes No

Have you done LIT or IVIG? Yes No When? _____

Have you taken oral contraceptives? Yes No
When _____ How long? _____

Have you ever had an IUD? Yes No
When _____ How long? _____

Have you ever taken Depo Provera? Yes No
When _____ How long? _____

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? Yes No
What was it? _____

Are you planning to do?

IUI _____ IVF _____ OTHER _____

Estimated date of procedure _____

What drugs/medications will you be taking in preparation for this procedure and when do you start?

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Male Fertility History

Do you have undescended testes? Yes No

Have you ever been diagnosed with a varicocele? Yes No

Have you had any urologic surgeries? Yes No

Have you experienced difficulty maintaining an erection?..... Yes No

Have you experienced difficulty ejaculating?..... Yes No

Have you had exposure to any known environmental toxins or hormones? Yes No

Have you experienced any penile discharge? Yes No

Do you regularly experience nocturnal emission?..... Yes No

Have you had a fertility workup?..... Yes No

If yes, what was your sperm count? __ Below normal __ Normal Number _____

What was the sperm motility? __ Below normal __ Normal Number _____

What was the sperm morphology? __ Abnormal __ Normal Number _____

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1314 Lincoln Ave. Suite 2F
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831 239 2623

CONSENT FOR ACUPUNCTURE TREATMENT

I hereby request and consent to acupuncture treatments and other procedures within the scope of the practice of acupuncture on me by the acupuncturist named below.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxa, massage, cupping, electrical stimulation, 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. I will immediately notify my acupuncturist 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 and/or numbness or tingling near the needling sites that may last a few days.

There have been rare instances reported in which a patient fainted, developed a scar or infections, experienced a spontaneous abortion, or sustained a pneumothorax (air in the chest cavity that could cause a collapsed lung). The herbs and nutritional supplements that have been recommended are considered safe in the practice of Chinese medicine. Some herbs may have undesirable effects in larger doses than we recommend. Some possible side effects of taking herbs are nausea, gas, stomachache, diarrhea or rashes. I will notify my acupuncturist if I am pregnant since some herbs can be harmful.

I do not expect my acupuncturist to be able to anticipate and explain all possible risks and complications of treatments, and I wish to rely on my acupuncturist to exercise good judgment during the course of treatment. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above 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 Signature: _____ Date: _____

Acupuncturist Signature: _____ Date: _____

Financial policy

I understand that health insurance policies are an arrangement between an insurance carrier and myself. I assume full responsibility for verification of benefits including which services are covered under my policy, portion of fees covered, and annual maximum of coverage. Furthermore, I understand that Dr. Alison Hunter will prepare any necessary reports and claim forms to assist me in collecting reimbursement from my insurance company and that I will collect the amount covered directly from my insurance company. Any amount paid to the provider will be reimbursed to the patient by check upon receipt. I clearly understand that all services rendered are charged directly to me and that I am personally responsible for payment in full at the time of service.

Your appointment time is reserved specifically for you. Therefore, we request at least 24 hours notice for any cancellation or rescheduling of appointment times. Repeat missed appointments or short notice cancellations may result in a missed appointment fee of \$50.00. Exceptions to this policy include cancellations due to illness, family or personal emergency, and last minute changes in scheduling of procedures with your medical doctor. Please notify us as soon as possible if you are unable to keep your appointment for any of these reasons.

Fee schedule:

Initial Visit with treatment \$140.00

Acupuncture \$85.00

Reproductive Organ Massage 50 minutes \$85.00

Reproductive Organ Massage 30 minutes \$50.00

Cash Price per visit \$75.00

Prepay packages are non-refundable and non-transferrable

Herb and supplement prices are variable according to medication prescribed and amount of medication prescribed

Please sign and date below stating that you have received and understand the above policies

_____ Date: _____