Fertility Acupuncture Intake Form

Please complete your intake form before your visit. All information is confidential.

First name:	Last name:
Date of birth:	Care card number:
E-mail:	Mobile phone:
Address:	
City:	Postal code:
Occupation:	
Gender:	☐ Female ☐ Male ☐ Non-binary ☐ Other _____

Emergency contact:	
Relationship to you:	
Phone:	
Guardian (if you are <18):	

Family physician name:	
Phone:	
How did you hear about Dr. Emilie Salomons?	

Please help me help you! Fill out in detail, the more thorough and open you are, the better I can support you.

Is there something about you or your health that I should know before we meet, so that I can better support your needs?
Main complaint / most important health goal (please describe):

Are you trying to conceive with a partner:	☐ Yes ☐ No
If so, what is their name:	
Have you received a diagnosis for your condition(s)?	☐ Yes ☐ No ☐ Not applicable
If yes--what is the diagnosis, by whom was it made and how long has it been persisting?	
Does anyone in your family have this condition?	☐ Your Siblings ☐ Mother ☐ Father ☐ Paternal Grandparent ☐ Maternal Grandparent ☐ Not Applicable
Have you ever been hospitalized and/or treated for *any* conditions, injuries, illnesses or medical diagnoses as well as any hospitalization?	☐ Yes ☐ No ☐ Not applicable
If yes, briefly explain with approximate dates:	
Have you had Acupuncture before?	☐ Yes ☐ No ☐ Not applicable
Rate your daily energy level on a scale of 1-10, where 1=can't get out of bed, 5=move through the motions, and 10=bounce out of bed: _____	
Rate your daily stress level on a scale of 1-10 where 1=no stress, 5=daily stresses but managing, and 10=stress interferes with my daily life: _____	
How many bowel movements do you have a day?	
How many hours of sleep do you get per night?	

Do you participate in the following activities? (Check all that apply, and list frequency per week.)	☐ Yoga ☐ Hot Yoga ☐ Biking ☐ Swimming ☐ Running ☐ Fitness Class ☐ Walking ☐ Gym ☐ CrossFit ☐ Extreme Sport ☐ Triathlete ☐ Marathon Training ☐ Other_____
Do you consume/use the following/how much per week?	☐ Cigarettes ☐ Alcohol ☐ Recreational Drugs ☐ Coffee ☐ Pop ☐ Sauna / Hot Tub
Please list any *prescription medication* (and dose) or *over the counter drugs* currently taking:	
Please list *herbal medicine* and *other supplements* (and dose) currently taking:	
Have you ever undergone hormone treatment?	☐ Yes ☐ No
If so, for what and for how long?	
Rate your sexual energy/libido:	☐ Low ☐ Average ☐ High
Have you been exposed to or received chemotherapy or radiation?	☐ Yes ☐ No
How long have you been trying to conceive?	
Have you been pregnant or created a pregnancy in the past?	☐ Yes ☐ No ☐ Not applicable
If so, how many times has there been a resulting birth?	

If you have children, please provide age of each child:	
Have you had any miscarriages and/or D&C and/or terminations?	☐ Yes ☐ No ☐ Not applicable
If yes, in what year(s), at how many weeks pregnant and were there any concerns or complaints?	
Are you currently undergoing assisted reproductive treatments (IUI, IVF, ICSI, superovulation, etc.)?	☐ Yes ☐ No ☐ Not applicable
If yes, at which fertility clinic?	☐ Olive Fertility Centre ☐ Genesis Fertility Centre ☐ Pacific Centre for Reproductive Medicine (PCRM) ☐ Grace Fertility Centre ☐ Victoria Fertility Centre ☐ Other: _____
Please list any allergies (food, drugs, environmental, etc.):	
Do you have any other information you would like to share prior to your appointment?	

IF YOU ARE TRYING TO CONCEIVE WITH YOUR OWN EGGS OR UTERUS, PLEASE FILL OUT THE FOLLOWING:

Is your menstrual cycle?	☐ Regular ☐ Irregular ☐ Not Applicable

Do you chart your cycle?	☐ No ☐ Yes ☐ BBT Charting ☐ Ovulation Sticks ☐ Saliva ☐ App
How old were you when you had your first menstruation?	
What is the date your last menses began?	
How many days do you bleed in total?	
How many days is your menstrual cycle (i.e. 26-30 days)?	
Do you ovulate on your own?	☐ Yes ☐ No ☐ Not applicable
On what day of your cycle do you ovulate?	
Do you experience pain around ovulation?	☐ Yes ☐ No ☐ Not applicable
Do you experience premenstrual symptoms (PMS)	☐ Yes ☐ No ☐ Not applicable
If yes, please check all that apply:	☐ Breast tenderness ☐ Cramps ☐ Acne ☐ Change in bowel ☐ Bloating ☐ Headaches ☐ Nausea ☐ Moodiness ☐ Fatigue ☐ Night sweats ☐ Sleep disturbances ☐ Other: _____
Check all that apply during menstruation:	☐ Cramping ☐ Clotting ☐ Heavy flow ☐ Moderate flow ☐ Light flow

Have you experienced any of the following:	☐ STD ☐ Chlamydia ☐ Pelvic inflammatory disease ☐ Uterine fibroids ☐ Polyps ☐ Pelvic adhesions ☐ Pelvic abnormalities ☐ Prolapsed uterus ☐ Unique shape of uterus ☐ Endometriosis ☐ PCOS (polycystic ovarian syndrome) ☐ Yeast infection (regularly) ☐ Bladder infections (regularly) ☐ Uterine or ovarian cancer
Have you ever had a cervical biopsy or operation? If yes briefly explain:	☐ Yes: _____ ☐ No
Have you taken/used contraceptives?	☐ Oral Contraceptives ☐ IUD (copper) ☐ IUD (hormonal) ie Mirena ☐ Depo-Provera ☐ Plan B pill ☐ Nuva Ring ☐ Condoms ☐ Other: _____
If yes, for how long/when did you stop?	
Have you had any hormone testing done?	☐ FSH ☐ Estrogen (E2) ☐ Progesterone ☐ Prolactin ☐ Thyroid (TSH) ☐ Testosterone ☐ AMH ☐ LH ☐ Other: _____
Have you had your uterine/fallopian tubes evaluated medically (HSG)?	☐ Yes ☐ No ☐ Not applicable

IF YOU ARE TRYING TO CONCEIVE WITH YOUR OWN SPERM, PLEASE FILL OUT THE FOLLOWING:

Do/did you have an undescended testicle?	☐ Yes ☐ No

Have you been diagnosed with a varicocele?	☐ Yes ☐ No
Have you ever had any urological surgeries? If so, please list:	☐ Yes ☐ No
Have you experienced the inability to achieve or maintain an erection?	☐ Yes ☐ No
Have you been exposed to any environmental toxins?	☐ Yes ☐ No
Have you experienced any penile discharge?	☐ Yes ☐ No
Do you regularly experience nocturnal emission?	☐ Yes ☐ No
Have you had a high fever in the past 6 months?	☐ Yes ☐ No
Do you currently have a prostate condition?	☐ Yes ☐ No
Have you been diagnosed with small or soft testes?	☐ Yes ☐ No
Have you been checked for a blockage of your reproductive tract?	☐ Yes ☐ No
Do you experience rashes on your groin or on your testicles?	☐ Yes ☐ No
Have you had a sperm analysis?	☐ Yes ☐ No
If yes, what were the results?	Motility _____ Morphology _____ Count _____
Have you had your testosterone tested? If yes, what were the results?	☐ Yes ☐ No

Consents

Accuracy of Information

☐ I certify that the above medical information is correct to my knowledge.

Privacy and Sharing of Information

I authorize the clinic and Dr. Emilie Salomons to collect my personal and medical information as documented above. In addition, I authorize the clinic and Dr. Emilie Salomons to communicate with my family doctor, midwife and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed with my permission.

☐ I agree

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in Dr. Emilie Salomons' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee.

☐ I am aware of the Cancellation Policy.

Informed Consent

While acupuncture and Chinese Medicine provided by Dr. Emilie Salomons has proven to be highly effective in correcting conditions and maintaining overall well-being, all practitioners in BC are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, Dr. Emilie Salomons will discuss these with you.

What are the possible side effects of acupuncture?

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive;
- Minor bleeding or bruising can occur from acupuncture;
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise Dr. Emilie Salomons if worsening of symptoms continues for more than 2 days;
- Fainting can occur in certain patients, particularly at the first treatment.

What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?

- Bruising (looks like a circular hickey) is a common side effect of cupping;
- The herbs and nutritional supplements 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 or inappropriate during pregnancy.

Is there anything Dr. Emilie Salomons needs to know? Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint, or other odd detached sensations;
- If you have a pacemaker or any other electrical implants;
- If you are pregnant;
- If you have a bleeding disorder;
- If you are taking anticoagulants (blood thinners) or any other medication;
- If you have damaged heart valves or have any other particular risk of infection.

Rare Complications

When administered by a properly trained and registered practitioner, acupuncture is considered a very safe procedure. Dr. Emilie Salomons uses single-use, sterile, disposable needles. However, although rare, significant complications have been reported in the literature that you should be made aware of. These include pneumothorax, perforation of an internal organ, infection, and nerve damage.

Again, as a registered BC acupuncturist/Dr. TCMs, rigorous training in safe needle techniques occurs, thus these complications are extraordinarily rare. If you have any questions or concerns in this regard, do not hesitate to speak with Dr. Emilie Salomons about it.

Please note that this form must be signed prior to your first appointment.

☐ I have read and agreed to the terms outlined above.

Electronically signed:	
Date:	

Note: After completion of this form, please save it to your computer (laptop or desktop preferred--phones and tablets may not work), and then e-mail to info@inletbirth.ca so we can upload the completed form to your chart. Thank you!