Catherine Brown
Riverina Natural Therapies
92 Fitzmaurice Street
Wagga Wagga NSW 2650
Ph: 0418 607 408
E: admin@ivffertilityacupuncture.com.au

GENERAL PATIENT INFORMATION - FEMALE

Please complete all questions if possible

First Name: _____ Last Name: _____

Sex: _____ Date of Birth: _____

Street Address: _____

Suburb: _____ Postcode: _____

Phone No. (Best Contact): _____

Email: _____

Do you have private health insurance? _____Yes / No

Name of Fund: _____

Are you covered for complementary therapies? _____Yes / No

How did you hear about us? _____

What is your occupation? _____

Do you enjoy your work? _____

How many hours per week do you work? _____

Is it stressful? _____

What are your duties? _____

Main Problems you would like us to help you with: _____

_____

How long ago did this problem begin? _____

Have you been given a diagnosis for this problem? ___ Yes / No

If so, what and by whom? _____

What kind of treatments have you tried? _____

_____

On a scale of 1-10, how would you rate your daily energy level (10 being best)? _____

Are your bowel movements regular? _____

How many times per day/week? _____

Are they formed, loose, constipated, or do they alternate from loose to difficult to pass?

_____

Do you experience urinary frequency, urgency, burning, dribbling, retention? _____ Yes / No

What colour/shade of yellow is it? _____

Do you have a history of urinary tract infections? _____ Yes / No

How many glasses of water do you drink in a day?_____

Please describe in general what you eat? (Organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.)

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

What do you crave (sweet, spicy, salty) _____

Do you have trouble falling asleep?_____ Yes / No

Do you wake throughout the night? _____ Yes / No

Are you a light sleeper? _____ Yes / No

How many hours of sleep per night do you have? _____

Do you have vivid dreams? _____ Yes / No

Do you have night sweats? _____ Yes / No

If you were asked to describe yourself from an emotional standpoint, what would you say?

ie: irritable, worrier, anxious, sad, impatient, stressed, etc._____

_____

Do you have a regular exercise program? _____ Yes / No

If yes, please describe? _____

_____

No. of cigarettes smoked per day? _____

How much coffee, tea, or cola do you drink per day?_____

Have you ever taken recreational drugs? _____ Yes / No

Do you still take them? _____ Yes / No

Do you use alcohol? _____ Yes / No

No. of Drinks per day? _____

Do you use a hot tub? _____ Yes / No

No. of times per week? _____

Drug Allergies

Are you allergic to any medications that you know of? If yes, please list them below:

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications or Supplements

Medication / Supplement	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Conditions
Please circle **Yes** for any / all that apply to **you**

German Measles (Rubella)_____ Yes
Migraine _____ Yes
Prolonged Dizziness _____ Yes
Thyroid Problems _____ Yes
Pneumonia _____ Yes
Tuberculosis _____ Yes
Asthma _____ Yes
Bronchitis _____ Yes
Other Lung Conditions _____ Yes
Heart Attack _____ Yes
Heart Murmur _____ Yes
Rheumatic Fever _____ Yes
Other Heart Conditions _____ Yes
High Blood Pressure _____ Yes
Gastric / Duodenal Ulcer _____ Yes
Hepatitis _____ Yes
Intestinal Bleeding _____ Yes
Bleeding Tendency _____ Yes
Diabetes _____ Yes
Kidney Stones _____ Yes
Kidney Infection _____ Yes
Other Kidney Disorders _____ Yes
Bladder Infection _____ Yes
Rheumatoid Arthritis _____ Yes
Other forms of arthritis _____ Yes
Lupus Erythematosus _____ Yes
Paralysis _____ Yes
Neurological Disorders _____ Yes
Thrombophlebitis _____ Yes
Varicose Veins _____ Yes
Breast Tumour (Benign) _____ Yes
Breast Cancer _____ Yes
Ovarian Cancer _____ Yes
Uterine Cancer _____ Yes
Other (please list) _____

_____

Previous Surgeries

Have you ever had surgery?_____ Yes / No. If yes, please complete this section

Procedure	Date	Indication	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family Medical Condition

Is there a history of any of the following conditions in the **family**?
Please select any / all that apply

Medical Condition	Select	Details
Diabetes _____	Yes	_____
Heart Disease _____	Yes	_____
High Blood Pressure _____	Yes	_____
Kidney Disease _____	Yes	_____
Multiple Births _____	Yes	_____
Mental Retardation _____	Yes	_____
Birth Defects_____	Yes	_____
Inherited Diseases _____	Yes	_____
Rheumatoid Arthritis _____	Yes	_____
Mental Illness _____	Yes	_____
Cancer_____	Yes	_____
Allergies (ie: Food, Dust) _____	Yes	_____
Drug Abuse _____	Yes	_____
Thyroid Disease _____	Yes	_____
Lupus Erythmatosis _____	Yes	_____
Blood Disorders _____	Yes	_____
Breast Cancer _____	Yes	_____
Ovarian Cancer _____	Yes	_____
Uterine Cancer _____	Yes	_____
Other Cancer _____	Yes	_____
Sickle Cell Disease_____	Yes	_____
Cystic Fibrosis _____	Yes	_____
Other_____	Yes	_____
Other_____	Yes	_____
Other_____	Yes	_____

FEMALE SPECIFIC INFORMATION
Please select any / all that apply to you?

Kidney Yin / Jing Deficiency
Do you have a lower back weakness, soreness or pain or knee problems? _____ Yes / No
Do you have ringing in your ears or dizziness? Is your hair prematurely grey? _____ Yes / No
Do you have vaginal dryness? _____ Yes / No
Do you have dark circles around or under your eyes? _____ Yes / No
Do you have night sweats or heat up at night? _____ Yes / No
Are you prone to hot flushes? _____ Yes / No
Do you experience fear in your life? _____ Yes / No

Kidney Yang Deficiency
Is your lower back sore or weak? _____ Yes / No
Do you have pre-menstrual lower back pain? _____ Yes / No
Are you feet and hands cold? _____ Yes / No
Are you typically colder than those around you? _____ Yes / No
Is your libido low? _____ Yes / No
Do you wake at night / early in the morning because you have to urinate? _____ Yes / No
Do you urinate frequently and is the urine diluted? _____ Yes / No
Do you have early morning loose bowels? _____ Yes / No
Does your menstrual blood tend to be dull in colour? _____ Yes / No
Do you feel cold cramps during your period that respond to heat pack? _____ Yes / No

Spleen Qi Deficiency
Are you often fatigued? _____ Yes / No
Is your energy lower after a meal? _____ Yes / No
Do you feel bloated after eating? _____ Yes / No
Do you crave sweets? _____ Yes / No
Do you have abdominal pain or digestive problems? _____ Yes / No
Are you hands and feet cold? _____ Yes / No
Is your nose cold? _____ Yes / No
Are you prone to heaviness or fogginess in the head? _____ Yes / No
Do you bruise easily? _____ Yes / No
Do you have poor circulation? _____ Yes / No
Do you have varicose veins? _____ Yes / No
Are you prone to worry? _____ Yes / No
Have you been diagnosed with low blood pressure? _____ Yes / No
Do you sweat a lot without exerting yourself? _____ Yes / No
Do you feel dizzy or light headed, or have visual changes when you stand up fast? _____ Yes / No

Is you menstruation thin, watery or pinkish in colour? _____ Yes / No

Are you more tired around ovulation or menstruation? _____ Yes / No

Do you ever spot a few days or more before your period comes? _____ Yes / No

Have you ever been diagnosed with uterine prolapse? _____ Yes / No

Are you often sick or do you have allergies? _____ Yes / No

Have you been diagnosed with anaemia? _____ Yes / No

Do you have haemorrhoids or polyps? _____ Yes / No

Blood Deficiency

Are your meses light and/or late? _____ Yes / No

Do you have dry flaky skin? _____ Yes / No

Are you prone to getting chapped lips? _____ Yes / No

Are you fingernails or toenails brittle? _____ Yes / No

Are you losing hair on your head? _____ Yes / No

Is your hair brittle or dry? _____ Yes / No

Do you have diminished night-time vision? _____ Yes / No

Do you get dizzy or light headed around your period? _____ Yes / No

Do you get shortness of breath? _____ Yes / No

Do you experience palpitations (feel your heart beat in your chest)? _____ Yes / No

Blood Stasis

Is your menstrual flow ever brown in colour? _____ Yes / No

Do you feel midcycle pain around your ovaries? _____ Yes / No

Do you experience periodic numbness of your hand or feet? _____ Yes / No

Do you have varicose veins or spider veins? _____ Yes / No

Does your menstrual blood contain clots? _____ Yes / No

Is your lower absomen tender to palpation (touch)? _____ Yes / No

Do you experience piercing or stabbing menstrual cramps? _____ Yes / No

Do you have dark spots in your vision? _____ Yes / No

Liver Qi Stagnation

Are you prone to emotional depression? _____ Yes / No

Are you prone to anger or rage? _____ Yes / No

Do you suffer from PMS? _____ Yes / No

Are your breasts sore or sensitive at ovulation? _____ Yes / No

Do you experience premenstrual breast distension or pain? _____ Yes / No

Have you been diagnosed with high prolactin levels? _____ Yes / No

Do you become bloated premenstrually? _____ Yes / No

Do you have difficulty falling asleep at night? _____ Yes / No

Do you experience hearbrun or wake up with bitter taste in your mouth? _____ Yes / No

Are your menses painful? _____ Yes / No

Do you feel your menstrual cramps in the external genital area? _____ Yes / No

Is the menstrual blood thick and dark, or purplish in colour? _____ Yes / No

Heart Dificiency

Do you wake up early in the morning and have trouble getting back to sleep? _____ Yes / No

Do you have heart palpitations, especially when anxious? _____ Yes / No

Do you have nightmares? _____ Yes / No

Do you seem low in spirit or lacking in vitality? _____ Yes / No

Are you prone to agitation or extreme restlessness? _____ Yes / No

Do you fidget? _____ Yes / No

Do you sweat excessively, especially on your chest? _____ Yes / No

Excess Heat

Is your pulse rate rapid? _____ Yes / No

Are you mouth and throat usually dry? _____ Yes / No

Are you thirsty for cold drinks most of the time? _____ Yes / No

Do youoften feel warmer than those around you? _____ Yes / No

Do you wake up seating or have hot flushes? _____ Yes / No

Do you break out with red acne? _____ Yes / No

Dampness

Do you feel tired and sluggish after a meal? _____ Yes / No

Do you have fibrocystic breasts? _____ Yes / No

Do you have cystic or pustular acne? _____ Yes / No

Do you have urgent, bright or foul smelling stools? _____ Yes / No

Does your menstrual blood contain tissue or mucous? _____ Yes / No

Do your joints ache, especially with movement? _____ Yes / No

Are you overweight? _____ Yes / No

Are you prone to yeast infections or vaginal itching? _____ Yes / No

Do you have damp, sticky, unformed stools? _____ Yes / No

GYNAECOLOGICAL HISTORY

Age of first period_____

When was the first day of your last period? _____

Are you periods regular? _____ Yes / No

Number of Days between periods? _____

Number of days of bleeding?_____

Amount of bleeding? _____ Light / Medium / Heavy / Clots

Have you ever needed medication to bring on your period? _____ Yes / No

Pain with menstruation? _____ Yes / No

Degree of pain: _____Mild / Medium / Severe

Does pain start with the onset of bleeding? _____

Does pain begins a few days prior to the onset of bleeding? _____

Is the pain relieved by over the counter medications? _____ Yes / No

If no, what relieves the pain? _____

Is the pain: _____ Stabbing / Cramping / Dull / Heavy / On and Off?

Do you experience pre-menstrual symptoms (PMS)?_____ Yes / No

If yes, please circle all that apply?

Breast tenderness / Cramps / Acne / Change in bowel / Bloating / Headaches / Nausea / Moodiness / Fatigue / Night sweats / Sleep disturbances /

Other (please list) _____

Do you ovulate on your own _____ Yes /No What Day? _____

Do you chart your cycle? _____ BBT / Ovulation Sticks / Saliva

Do you experience pain around ovulation? _____ Yes / No

Do your breasts get tender around ovulation? _____ Yes / No

Do you notice stretchy clear egg white slippery cervical mucous around ovulation? _____ Yes / No

Do you experience spotting mid cycle?_____ Yes / No

Do you experience pain with sexual intercourse?_____ Yes / No

If yes, is pain mostly on the exterior? _____

If yes, is pain mostly internal (deep penetration)? _____

Are you experiencing vaginal discharge?_____ Yes / No

If yes, what colour is the discharge _____ White / Yellow / Green / Pinkish / Red

Associated itching and burning? _____ Yes / No

Associated with an unusual odour?_____ Yes / No

Do you have a Gynaecologist?_____ Yes / No

When was your last pap smear? _____

What was the result? _____

Was any follow up needed? _____

Have you ever had a cervical biopsy or operation?_____ Yes / No

Do you get yeast infections regularly? _____ Yes / No

Do you get bladder infections regularly?_____ Yes / No

Have you ever had a sexually transmitted disease? _____ Yes / No

If yes, please complete the following for all that apply?

Chlamydia _____ Yes / No When ____ Treatment_____

Gonorrhoea _____ Yes / No When ____ Treatment_____

Syphilis Y/N _____ Yes / No When ____ Treatment_____

Herpes Y/N _____ Yes / No When ____ Treatment_____

Other_____ When ____ Treatment_____

Have you ever had Pelvic Inflammatory Disease (PID) _____ Yes / No

When_____

Where you hospitalised? _____ Yes / No

Have you ever used an IUD? _____ Yes / No

Have you ever used the Oral Contraceptive Pill? _____ Yes / No

If yes, how many years? _____

When did you last use it? _____

Have you ever taken Depo-Provera? _____ Yes / No

Have you ever been diagnosed with 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 ever been diagnosed with pelvic abnormalities? _____ Yes / No

Have you ever been diagnosed with PCOS? _____ Yes / No

Have you recently had an ultrasound? _____ Yes / No

OBSTETRIC HISTORY

Have you ever been pregnant before? _____ Yes / No

Are you currently pregnant? _____ Yes / No / Unsure

How long have you been trying to have a baby?_____

Pregnancy Details

Date	Current / Prior Partner	Live Birth? (Y/N)	Miscarriage Abortion Ectopic?	Wks	Foetal heart? (Y/N)	D&C? Y/N	Mode of Delivery?	Sex	Complications

Fertility – IVF Treatments

ART (Assistive Reproductive Technology)

Have you undergone or are you currently undergoing any of the following ART procedures:

Ovulation Induction? _____ Yes / No

IUI (please give year and month)? Yes / No Year_____ Month _____

Name of fertility specialist and centre?_____

IVF

How many stimulated cycles have you had?_____

Cycle 1:

No. eggs collected _____ No. fertilized _____ No. transferred _____ No. frozen _____

FSH _____ Positive pregnancy Test Y/N Date Started _____

Cycle 2:

No. eggs collected _____ No. fertilized _____ No. transferred _____ No. frozen _____

FSH _____ Positive pregnancy Test Y/N Date Started _____

Cycle 3:

No. eggs collected _____ No. fertilized _____ No. transferred _____ No. frozen _____

FSH _____ Positive pregnancy Test Y/N Date Started _____

Cycle 4:

No. eggs collected _____ No. fertilized _____ No. transferred _____ No. frozen _____

FSH _____ Positive pregnancy Test Y/N Date Started _____

How many frozen transfers have you had?

Date ____/ ___ /____ No. of eggs transferred ___ Progesterone Y/N + Pregnancy test Y/N

Date ____/ ___ /____ No. of eggs transferred ___ Progesterone Y/N + Pregnancy test Y/N

Date ____/ ___ /____ No. of eggs transferred ___ Progesterone Y/N + Pregnancy test Y/N

Date ____/ ___ /____ No. of eggs transferred ___ Progesterone Y/N + Pregnancy test Y/N

Date ____/ ___ /____ No. of eggs transferred ___ Progesterone Y/N + Pregnancy test Y/N

If you have had cancelled IVF cycles please detail below:

_____

_____

_____

_____

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INFORMED CONSENT FORM

The therapies offered by Catherine Brown Practitioner of Traditional Chinese Medicine have a long history of safe practice, however here are some risks associated with any sort of treatment. Below is a list of potential risks associated with the Traditional Chinese Medicine therapies. All treatments will be explained to you before commencement. The best way to reduce the chance or risk is to answer all questions about your health fully and honesty, if you require further information or have specific questions please ask.

Outline of possible risk	**Therapy**	**Strategies to minimise possible risk**
Pain	Acupuncture Cupping Electro-Acupuncture	Tell your practitioner if you have sensitive skin and become uncomfortable or experience pain during treatment.
Bruising	Acupuncture Cupping Electro-Acupuncture	Tell your practitioner if you bruise easily or have a bleeding disorder. Cupping may leave bruises that are usually painless and may last over a week. It is important to tell the practitioner if bruises in the area being cupped are cosmetically unacceptable.
Infection	Acupuncture Cupping	It is possible to develop an infection whenever the skin is punctured so please inform the practitioner if you have a known immune deficiency so special precautions can be taken. Pre-sterilised single use needles are used in this clinic.
Burn	Moxibustion Heat lamp	Please advise the practitioner if you have sensitive skin and if heat used during treatment is uncomfortable.
Relaxed or Sleepy	Acupuncture Cupping Moxibustion	It is common to feel relaxed or sleepy after treatment therefore avoid getting up quickly from the treatment table and give yourself time to adjust after the treatment before driving or using stairs. Avoid driving immediately if you feel sleepy.
Drug Herb Interactions	Herbal Medicine	It is important to tell the practitioner about all medications and herbal or nutritional supplements that you are currently taking or have recently stopped taking, as interactions between herbal medicine & Western medicine are possible. Chinese herbal medicine & supplements prescribed are considered safe although some maybe toxic in large doses or inappropriate during pregnancy.
Fainting	Acupuncture Cupping Massage	Do not skip a meal before treatment. Get up slowly after the treatment
Aggravation	Any therapy	It is possible that your condition could be

of your condition		aggravated. This is uncommon but can occur.

Please notify the Practitioner if you have an INFECTIOUS DISEASE, are a HAEMOPHILIAC, have an existing HEART CONDITION, PACEMAKER, are on BLODD THINING MEDICIATION, are PREGNANT, suffer form EPILEPSY or have suffered SEIZURES.

Please be aware that the above information is required in order for this practice to provide you with appropriate health care services. Failure to disclose any information regarding your health may affect the practitioner's ability to deliver these services you safely.

I confirm I have read and understand the risks outlined above are possible and agree to undergo treatment of Traditional Chinese Medicine from this clinic.

PRIVACY POLICY

I understand the practitioner may review my medical records and lab reports and that all my records will be kept secure & confidential and will not be released without my written consent.

Signed: _____

Date: _____

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CANCELLATION & RESCHEDULING POLICY CLIENT AGREEMENT

Welcome to Fertile Qi, we are delighted to have you as a patient & look forward to providing you with the highest quality care. We understand there are times when you may need to cancel and / or reschedule your appointment and we are pleased to accommodate your needs.

However due to increasing demand for our services we are implementing a cancellation fee. Therefore, it is our policy that all cancellations and / or rescheduled appointments are to please take place 24 hours prior to the date of your originally scheduled appointment.

If you are reasonably unable to fulfil these requirements or you miss a booked appointment, 50% of the scheduled service fee will be charged and an account issued.

This policy allows us time to schedule another patient that would also benefit from treatment. Thank you for your understanding.

Full Name _____

Signature _____

Date _____