DrewNesbitt.ca

**Acupuncture ● Chinese Herbal Medicine ● Orthomolecular Nutrition**

1533 Danforth Ave. ● Toronto, ON ● M4J 5C3 ● 416-465-3304

# Fertility Health History Form - Female

Name: _____ Date of birth: _____ Gender: M F

Address: _____ City: _____ Postal Code: _____

Home phone: _____ Alternate phone #: _____

E-mail address: _____@_____

Profession: _____ Full-time or part-time? (circle)

Emergency contact: _____ Relationship: _____

How did you hear about Drew? _____

## FERTILITY BACKGROUND

How long have you been trying to conceive?

_____

Are you working with any other fertility specialists or clinics?

1._____
2._____

Have you received a diagnosis regarding your fertility (i.e. luteal phase defect, PCOS, unexplained infertility)?

_____
_____

Has your male partner received any testing regarding fertility? If yes, what were the results?

_____

Have you ever used fertility drugs (including clomid) - which ones?

_____
_____

Have you ever done IVF? IUI? ICSI? Please describe.

_____
_____

Do you have any children? If yes, what are their ages?

_____

Have you had any past pregnancies? If so, when?

_____

Have you had any miscarriages? How many and when?

_____
_____

Please describe any past therapies you have tried related to your fertility: (naturopathic, acupuncture etc.)

_____
_____
_____

Do you have any additional health complaints? (Energy, thyroid, digestion, mood, sleep, skin, autoimmune disorders, frequent illness, anxiety, etc...)

1. _____
2. _____
3. _____
4. _____

Is there anything else about your health you feel we should know prior to your initial consultation?

_____
_____

**Menstrual History**

Regular menses cycle? Yes ____ No ____ Clots? Yes ___ No ___

Average length of full cycle (i.e. 28 days?) ____ How many days of bleeding? ____

Pain or Cramping? Yes ____ No ____ Flow: Heavy ___ Medium ___ Light ____

Abnormal Discharge? Yes____ No ____ Date of first day of last period: _____

Have you ever been on the birth control pill or any other form of hormonal contraception?_____

If yes, what type?_____For how long?_____

**Are you currently under the care of any of the following medical professionals?**

- ❑ Medical Doctor
- ❑ Chiropractor
- ❑ Acupuncturist
- ❑ Physical Therapist
- ❑ Naturopath
- ❑ Massage Therapist
- ❑ Nutritionist
- ❑ Psychiatrist
- ❑ Other: _____

## Please check all that apply:

**Musculoskeletal System**
- ❑ Arthritis
- ❑ Artificial Joint
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Joint Pain
- ❑ Muscular Dystrophy
- ❑ Osteoporosis
- ❑ Plantar Fascitis
- ❑ Tendonitis
- ❑ Whiplash

**Respiratory System**
- ❑ Asthma
- ❑ Allergies
- ❑ Bronchitis
- ❑ Sinusitis
- ❑ Frequent Cold/ Flu

**Circulatory System**
- ❑ Atherosclerosis
- ❑ Thrombosis
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Stroke
- ❑ Varicose Veins
- ❑ Poor Circulation

**Digestive System**
- ❑ Recent change in appetite
- ❑ Acid Reflux
- ❑ Diarrhea
- ❑ Constipation
- ❑ Ulcers
- ❑ Food Allergies
- ❑ Gall Stones
- ❑ Hepatitis

**Immune System**
- ❑ Cancer
- ❑ Chronic Fatigue Syndrome
- ❑ Fibromyalgia
- ❑ Diabetes
- ❑ Edema
- ❑ HIV/AIDS
- ❑ Lupus
- ❑ Lymphoma

**Nervous System**
- ❑ Alzheimer's
- ❑ Headaches or Migraines
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Seizures
- ❑ Sleep Disorders
- ❑ Shingles
- ❑ Spinal Cord Injury

**Integumentary System (Skin)**
- ❑ Burns
- ❑ Dermatitis
- ❑ Eczema
- ❑ Fungal Infections
- ❑ Impetigo
- ❑ Scars
- ❑ Rash

**Emotions**
- ❑ Depression
- ❑ Anxiety
- ❑ Grief
- ❑ Anger

**Female Reproductive System**
- ❑ Irregular Menstruation
- ❑ Painful Menstruation
- ❑ Difficult Conception
- ❑ Miscarriage
- ❑ Endometriosis
- ❑ Menopause
- ❑ Hysterectomy

**Urinary System**
- ❑ Frequent Urination
- ❑ UTI
- ❑ Kidney Stones

# Consent for Treatment

*Please read the information below carefully and ask Drew if there is anything that you do not understand. Once completed, please sign and date the form below.*

**Treatment Options:** Your treatment may include acupuncture, Chinese herbs, moxibustion, cupping, electro-acupuncture, acupressure, dermal friction (Gua Sha), infra-red (heat lamps), therapeutic exercises and nutritional counselling.

Treatments are based on the theories of Traditional Chinese Medicine (TCM) and do not, in any way, take the place of treatment or a diagnosis by a medical doctor.

**Potential side-effects of treatment:**

When performed correctly, acupuncture is extremely safe. However, you need to be aware of the following:

- Drowsiness may occur after treatment in a small number of patients.
- Minor bleeding or bruising may occur after acupuncture treatments.
- Fainting can occur in certain patients, particularly at the first treatment. Lying down during treatment drastically reduces this issue. Tell your acupuncturist if you feel light headed during treatment.
- Some acupuncture points are contraindicated in pregnancy, please inform Drew if you are currently pregnant or are trying to get pregnant.
- Pnuemothorax (collapsed lung) is a condition which can occur if deep needling is performed on the chest or back. This is extremely rare. Please tell your practitioner if you experience chest pain post treatment.

**Drew uses only single-use, sterile, disposable needles in his clinic. Drew is Clean Needle Technique (CNT) certified from the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) from the U.S.**

**It is important to let your practitioner know the following:**

- if you have ever experienced anxiety surrounding needles or are prone to fainting
- if you have a pacemaker or any other electrical implants
- if you have a bleeding disorder
- if you are taking anti-coagulants or any other medication
- if you have damaged heart valves or have any other particular risk of infection (suppressed immune system)
- if you are pregnant or trying to get pregnant

**Consent**

I consent to the performance of acupuncture and other TCM techniques with Drew Nesbitt BA, TCMP, Ac., ROHP. I understand that I am free to withdraw my consent and that I may stop treatment at any time. I understand that my signature on this form indicates that I have read and understood the preceding information regarding my treatment. I understand that if I have any questions about this information, I should ask my acupuncturist. I also understand that if I fail to cancel an appointment within 24 hours notice, I will be charged the full amount of my session.

Print name: _____ Signature: _____

Date: _____