Victoria V. Fabacher, L.Ac., LCSW

Patient Intake Form

Name: ____

Street Address: ____

City, State, Zip: ____

Home phone: ____________________ Cell phone: ____________________

SSN: ____________________ DOB: ____________________

Insurance Information: ____

____

Name of Primary Care Physician ____________________ phone # ______________

Name of Gynecologist/Obstetrician: ____________________ phone # ______________

Reason for Visit ____

General Medical Background:

Do you have any medical conditions I should know about? ______________________________

What medications do you take on a regular basis? ______________________________

For what? ____

Describe any injuries, surgeries or major illnesses you have had: (include age and length of illness, etc.)

a) BIRTH ____

b) CHILDHOOD ____

c) ADULTHOOD ____

Do you have any scars or calluses? YES NO Where? ______________________________

Family medical history

Mother ____

Father ____

Grandparents ____

Siblings ____

Diet and Food

How is your appetite? ______________ Any food allergies ______________________________

Food cravings? ____

List any vitamins or supplements you are taking: ______________________________

Describe your typical meal:

Breakfast: ____

Lunch: ____

Dinner: ____

What do you like to snack on? ____

Do you smoke cigarettes/cloves/marijuana? If yes, how much per day? ______________________

How many glasses per day of: Water _____ Soda _____ Coffee/Tea _____ Wine/Beer _____ Mixed drinks ____

Rate your taste preferences from 1-5, 1= like most, 5 =like least: ___ Sweet___ Sour___ Salty ___Spicy ___Bitter

Gastrointestinal

Do you experience now, or have you experienced in the past, any of the following:

___belching ___ nausea ___vomiting ___ulcers ___bloating ___heartburn ___acid regurgitation ___ hernia

___indigestion ___ severe stomach pain ___painful bowel movements ___constipation ___hard stool ___diarrhea

___ loose stools ___undigested food in stool ___hemorrhoids ___ anal itching ___ blood in stool

Urogenital

Urination: _____ times per day Color: (circle) pale yellow - medium yellow - dark yellow/orange

Ever have: _____ trouble starting stream _____frequent urination _____incontinence _____ pain on urination

_____ dribbling when sneezing _____ UTI _____bladder infection _____blood in urine _____kidney stones

Aches and Pains

Describe any physical pain you currently experience ______________________________________

____

Are you prone to headaches? YES NO Describe when and where ______________________

Cardiovascular

Blood pressure: _____/_____ Have you ever been diagnosed with heart trouble ? YES NO

Do you experience now or have you experienced in the past, any of the following:

_____ chest pain _____ palpitations _____ varicose veins _____ phlebitis _____cold hands & feet

_____ irregular heart beat _____ poor circulation _____ anxiety _____ depression _____ other ____________

Any other medical or psychological issues you would like to discuss? ______________________

____

____

Gynecological background:

Age of first menstruation: ______ Date of last menstrual period: ______ Average# days between cycles : ______

Average # of days of bleeding: __________ Any questions or information you feel is important/unusual about

your monthly cycle? ____

How is your sexual energy? Please report any concerns you may have: ______________________________

____

Did you ever take birth control pills? YES NO How long and when did you stop? ___________________

Total # of pregnancies: _______ Live births: ______ Miscarriages: ______ Terminations ______

Have you ever received a Western medical diagnosis for any gynecological problem? YES NO

If yes, what and when was the diagnosis? ____

How has it been resolved? ____

Have you ever been diagnosed with a sexually transmitted disease ? YES NO
Have you been tested for HIV? YES NO

Do you experience now or have you experienced in the past, any of the following:

____ pain during intercourse ____irregular menstruation ____large clots during menstruation

____ vaginal itching/burning ____ spotting between periods ____ over 7 days of bleeding during menstruation

____ "PMS" symptoms ____ pain before or during menstruation ____ pain after menstruation

____ vaginal discharge: when? ______________________________ color? ____________________________

Explain eanything checked above: ____

Do you experience symptoms you associate with menopause? If so please list: ________________________

____

Are you currently trying to get pregnant? YES NO If not, please skip to page 5
Are you currently pregnant? YES* NO

If yes, due date of baby ________________________ gender if you know _________________________

Have you had any complications so far during this pregnancy? ______________________________________

Any complications during previous pregnancies? ____

Were you ever on bed rest or modified activities while pregnant? YES NO N/A
Have you ever been diagnosed with diabetes or hypertension while pregnant? YES NO N/A

*Though acupuncture is generally safe, there are increased risks during pregnancy that will be explained. You are encouraged to discuss your desire for acupuncture treatment with your obstetrician and gain his/her consent. You will be required to sign a separate consent form.

Fertility

How long have you been having "unprotected" sexual relations in effort to conceive? ________________________

Are you charting your temperature on a daily basis? YES NO **If yes, please provide copies of charts.**

If you are not taking your temperature, what other methods are you utilizing to determine when you are ovulating?

____

Have you seen your gynecologist or a Reproductive Endocrinologist to address trying to conceive? If so, please provide blood work levels for the following:

________FSH ________ LH _________ estradiol _________ progesterone _________ other

have you had your thyroid tested? If so, what is your TSH level? ___________ T3? __________ T4? ____________

Do you know if you have any structural problem that may be preventing pregnancy? YES NO

Have you had a hysterosalpingogram (HSG)? YES NO Results ____________________________________

Any other procedures like an endometrial biopsy, laparoscopy? If so for what reason/findings?________________

____

If you were born before 1972, do you know if your mother was given DES while pregnant with you? YES/NO

Do you have a history of any of the following that you know of:

_____uterine fibroids _____ ovarian cysts _____endometriosis _____ polycystic ovary

Has your partner's sperm been tested for abnormalities? **If testing has been performed, please provide a copy of results.**

Have you used any assisted reproductive technology (ART)? If so, which of the following:

_____ IUI un-medicated Date: _______ Results: ____

_____ IUI medicated Date: _______ Results: ____

_____ IVF Date: _______ Results: ____

_____ ICSI Date: _______ Results: ____

Are you planning to try again with ART? YES NO If so, when? ________________________________

Have you discussed with your doctor combining ART with acupuncture treatment? YES NO

Anything else you think I should know about your gynecological history or efforts trying to conceive a child?

____

____

Survey: Would you be interested in participating in a weekly support group with women who are experiencing similar issues? YES NO

Please check off any of the following statements that describe you:

_____ My menstrual blood is brown or blackish color
_____ My menstrual blood contain clots
_____ I feel pain in my ovaries around mid-cycle
_____ I have painful, unmovable breast lumps
_____ I experience periodic numbness of my hands and feet (especially at night)
_____ I have been diagnosed with endometriosis or fibroids
_____ I have piercing or stabbing menstrual cramps
_____ I have been diagnosed with a vascular problem or blood clotting disorder

_____ I am prone to emotional depression
_____ I am prone to anger or rage
_____ I become irritable before my period
_____ I feel bloated or irritable around ovulation/mid-cycle
_____ My breasts sensitive or sore around mid-cycle/ovulation
_____ I have been diagnosed with elevated prolactin levels
_____ I become bloated before my period
_____ I have difficulty falling asleep at night
_____ I experience heartburn or have a bitter taste in my mouth
_____ My menstrual blood thick and dark or purplish in color

_____ I wake up very early in the morning and have difficulty falling back to sleep
_____ I have heart palpitations
_____ I have nightmares
_____ I seem low in spirit or feel I lack vitality
_____ I am prone to agitation or restlessness
_____ I fidget
_____ I sweat excessively, especially on my chest and palms

_____ My mouth and throat are usually dry
_____ I am thirsty for cold drinks most of the time
_____ I often feel warmer than those around me
_____ I wake up sweating or have hot flashes at night
_____ I break out with red acne before my period
_____ My menstrual cycle is short, e.g. comes every 3 weeks instead of 4
_____ I have vaginal irritation or rashes

_____ I feel like I want to take a nap after a meal
_____ I have fibrocystic breasts
_____ I have cystic or pustular acne
_____ I have urgent, bright or foul-smelling stool
_____ My menstrual blood contain stringy tissue or mucus
_____ I am prone to yeast infections or vaginal itching
_____ My joints ache, especially with movement

_____ I have foul-smelling, yellow or greenish vaginal discharge
_____ I am prone to vaginal or rectal itching right before my period
_____ My lower abdomen feel cooler to the touch than the rest of my trunk

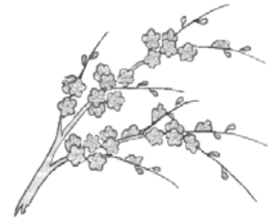
_____ I have lower back weakness, soreness, pain or knee problems
_____ I have ringing in my ears or dizziness
_____ My hair is prematurely gray
_____ I have vaginal dryness
_____ My mid-cycle cervical mucus is scanty or absent
_____ I have dark circles around my eyes
_____ I sweat at night/while sleeping
_____ I am prone to hot flashes
_____ I would describe myself as afraid a lot

_____ I have lower back pain before my period
_____ My feet are cold, especially at night
_____ I am typically colder than others I know
_____ My libido is low
_____ I wake up in the middle of the night to urinate
_____ I urinate frequently during the day and is it pale and a large amount
_____ I have early morning loose, urgent stools
_____ I have profuse vaginal discharge
_____ My menstrual blood tend to be pale colored
_____ I have cramps during my period that feel better with a heating pad

_____ I am often fatigued
_____ I have a poor appetite
_____ My energy is low after a meal
_____ I feel bloated after eating
_____ I crave sweets
_____ I have loose stools in general
_____ My hands and feel generally cold
_____ My nose is usually cold
_____ I am prone to feeling heavy or sluggish
_____ I bruise easily
_____ I think I have poor circulation
_____ I have varicose veins
_____ I am lacking strength in my arms and legs
_____ I am lacking exercise
_____ I am prone to worrying
_____ I have been diagnosed with low blood pressure
_____ I tend to sweat without exercising or exerting myself physically
_____ I feel dizzy or lightheaded when I stand up fast
_____ My menstrual blood thin, watery, profuse or pinkish in color
_____ I am tired around ovulation and/or menstruation
_____ I do “spot” a few days before my period comes
_____ I get a “bearing down” sensation in my uterus when I have my period
_____ I am often sick or I have allergies
_____ I have been diagnosed as hypothyroid or anemic

_____ My period is scanty (very light flow) or late
_____ I have dry, flaky skin
_____ I am prone to getting chapped lips
_____ My fingernails or toenails are brittle
_____ My hair is dry or brittle
_____ I am losing hair from my head (all over, not in patches)
_____ I have diminished night time vision
_____ I get dizzy or lightheaded around the time of my period

Victoria Virtue Fabacher, L.Ac., LCSW



Consent for Treatment

I, ___________________________________voluntarily consent to be treated with acupuncture by Victoria Fabacher, hereinafter referred to as “the acupuncturist”.

By initialing next to each item and signing my name below, I certify that I have read and fully understand all the information described and give my permission to be treated with acupuncture. I may also ask the acupuncturist for more detailed information before initialing or signing this form and my consent can be withdrawn at any time.

A. As part of treatment with acupuncture, one or more of the following modalities may be incorporated:

_____ **1. Acupuncture**. This is the insertion of very fine, sterile, filiform needles into specific acupuncture points in the body recognized to be effective for specific health problems.

_____ **2. Electro-Acupuncture**. This is the addition of small electrical currents through the acupuncture needles. Electro-stimulation is often used in conjunction with acupuncture as it has been shown to decrease pain, accelerate tissue healing, and reduce inflammation and swelling.

_____ **3. Moxabustion**. This is the process of burning an herb called Mugwort. It results in the application of heat to the skin and can be used either directly via loose moxa placed on the body over a layer of protective cream or indirectly with a moxa pole. It is most often used in conditions with the presence of cold.

_____ **4. Cupping**. This technique involves creating a vacuum under several glass “cups” and placing them on the body.The suction created by the cups stimulates circulation and is used for many conditions, including back pain and common colds. The treatment leaves purple or red circles at the site of cupping which fade in a few days.

_____ **5. Chinese Herbs**. Herbal therapy may be recommended to enhance wellness. If I wish to take herbs, I must do so per written and verbal instructions of the acupuncturist. Side effects are rare, but should I experience any uncomfortable changes that I associate with taking the herbs, I will discontinue use and contact the acupuncturist immediately. Symptoms may include, but are not limited to, changes in bowel habits, abdominal pain or discomfort, headache, gas, nausea or vomiting, rashes, hives and/or a tingling sensation of the tongue.

_____ **6. Nutritional Counseling.** Chinese dietary therapy is one of the pillars of Chinese medicine. The use of food as medicine is deeply rooted in Chinese culture and specific dietarty recommendations may be made as part of my treatment.

B. _____ I will notify the acupuncturist if I am trying to get pregnant OR suspect I am pregnant.

C. _____ I understand that there are treatment alternatives, which may be better suited to address my condition. I understand that the acupuncturist is not a medical doctor and I have been advised by the acupuncturist to discuss my condition(s) with my primary healthcare provider.

D. _____ I am aware that that while acupuncture is generally safe, there are potential side effects to treatmen such as drowsiness, possible bruising or bleeding and that symptoms can intensify before they lessen. Other more rare occurrences include spontaneous miscarriage, nerve damage or organ puncture, including lung puncture (pneumothorax). Infection is also another possible risk however the acupuncturist uses only sterile and disposable needles which are inserted one time and then discarded to minimize this risk. Should I experience any adverse symptoms for more than 24 hours I will contact the acupuncturist as well as my primary healthcare provider. Should I have any difficulty breathing, no matter how slight, I will call 911 or go to the emergency room immediately.

E. _____ I understand that I will NOT be treated if I have not eaten or if under the influence of alcohol/drugs.

Signature: ______________________________________ Date: ___________________

Victoria V. Fabacher, L.Ac., LCSW

Notice of Privacy Practices

This notice describes how health information about you is protected or may be used and disclosed and how you can gain access to this information. Please review it carefully.

Respect for patient privacy is highly valued. Confidentiality of all information that may reveal your identity will be maintained as required by law.

Required permission to use and disclose your protected health information (PHI)

I will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment for that treatment and conduct operations specific to my practice. This general written consent will be obtained the first time I provide you with treatment or services. This consent gives broad, general permission that does not need to be repeated each time I provide you with treatment or services. At times, other more specific consent may be obtained for particular services including, but not limited to providing acupuncture during the last weeks of pregnancy, or should specific information need to be disclosed to or obtained from a third party in effort to ensure that all providers are working together to ensure you receive appropriate care.

How I may use and disclose your health information

Health information about you is used for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care you receive. Health information about you may be disclosed to other practitioners for educational purposes or for continuity of service should another practitioner see you in my absence.

Your Rights

You have the right to look at health information about you. You may request in writing, to receive a copy of any information at a copying charge of ten (10) cents per page. If you believe that information in your record is incorrect, you have the right to request that such information be corrected.

My Legal Duty

I am required by law to protect the privacy of your information, provide this notice about my information sharing practices, follow such practices as described and seek your acknowledgement of this notice. You will be notified in writing of any significant changes in my personal policies or changes in policies dictated by law.

Please note that as a Mandated Reporter, I am required by law to report any suspect of child abuse, child endangerment or neglect to the proper authority.

Complaints

If you are concerned that I have violated your privacy rights or you disagree with a decision I made about access to your records, you may contact:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Telephone: 202-619-0257/877-696-6775

Patient Signature ______________________________________ Date Signed: ______________________

Patient Acknowledgement of receipt of copy (please initial): _________________

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