



359 SAN MIGUEL DR. SUITE 303, NEWPORT BEACH, CA 92660
PHONE: (949) 424-8956 | EMAIL: drkelly@acupunctureoc.com WEBSITE: <http://acupunctureoc.com/>

WOMEN FERTILITY NEW PATIENT INTAKE FORM

Today's Date ____/____/____

General Patient Information: all information provided is strictly confidential.

Last Name: _____ First Name: _____

Street address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Email: _____

Date of Birth: ____/____/____ Age _____ Sex: F/M Marital Status M S D W P _____

Occupation/Employer _____ Social Security # _____

HISTORY

Reason for your visit today: _____

Complaint is result of: Auto accident Injury Job Related Other Date

of the accident/injury/other ____/____/____

How long have had this condition? _____ Is it getting worse? Y N

Does it affect your: Sleep _____ Work _____ Other _____

What seemed to be the initial cause? _____

What makes it better? _____

What makes it worse? _____

Are you under physician's care? Y/N

Dr. Name _____ Phone: _____



AK-U-PUNCTURE
GLOBAL WELLNESS

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Reason you decided to try Acupuncture _____

Allergies _____

Surgeries _____

Please list ALL medications and supplements you are currently taking:

Medications/Supplements/ Dosage	Reason/Objective	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FINANCIAL ARRANGEMENTS

CASH CHECK CREDIT DEBIT

INSURANCE INFO: ADDRESS: _____

COMPANY NAME _____ SUBSCRIBER ID _____

Group Number _____

Referred By: Name _____ Address _____

CONSENT

I have read the above information and verify it to be true and correct to the best of my knowledge and hereby authorize this office to do whatever is necessary, in accordance with the state statutes, for the care and management of this complaint to be treated by Dr. Ata Kelly, L.Ac
I accept full financial responsibility for all medical services performed on my behalf.

Date ____/____/____

Patient Signature _____



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Family Medical History: *(Please check any and all condition(s) members of your family have had)*

Illness:	Father	Mother	Sibling(s)	Grandparents	Aunt/Uncle
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
Allergies	_____	_____	_____	_____	_____
Drug Abuse	_____	_____	_____	_____	_____
Alcoholism	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____
Strokes	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____

General Health Information:

Major Health Complaints and/or Symptoms:

1. _____
2. _____
3. _____

Please explain how these conditions affect or impair your daily activities:

Describe your symptoms when they are at their worst:

What makes your symptoms better?

Are there any other complaints or conditions that you would like us to know about?

Please list any non-prescription drugs or recreational drugs you currently take:

Medical Conditions/History: *(Circle any conditions you have had, or are currently experiencing)*

Aids/HIV	Cancer	Hepatitis	Osteoporosis	Stroke
Alcoholism	Diabetes	Herpes	Pacemaker	Thyroid Disorder
Allergies	Emphysema	Lyme Disease	Pnuemonia	Tuberculosis
Appendicitis	Epilepsy	High Blood Pressure	Polio	Typhoid Fever
Arteriosclerosis	Goiter	Measles	Rheumatic Fever	Ulcers
Arthritis	Gout	Menopause	Scarlet Fever	Venereal Disease
Asthma	Heart Disease	Multiple Sclerosis	Seizures	

Gynecological History:

Age at your first period: _____
 The first day of your last period? _____
 Are your periods regular? YES NO _____
 Number of days between periods: _____
 Number of days of bleeding: _____
 Amount of bleeding? (*circle one*) LIGHT - - - - MEDIUM - - - - HEAVY
 What color is the blood? PURPLE BROWN BLACK BRIGHT RED PINK
 Is there clotting? YES NO
 Do you bleed or spot between periods? YES NO
 Have you ever taken medication to bring on your period? YES NO
 Do your breasts become tender pre-menstrually? YES NO
 Do you have pre-menstrual low back pain? YES NO
 Do you have pain with menstruation? YES NO
 Degree of pain: MILD - - - - MODERATE - - - - SEVERE
 Pain relieved by over-the-counter medications? YES NO
 Does the pain start with the onset of bleeding? YES NO
 Begin before the onset of bleeding? YES NO
 Persist more than 48 hours? YES NO

Do you ovulate on your own? YES NO
 Do you experience pain during ovulation? YES NO
 On which day of your cycle do you ovulate? _____
 Do you have vaginal discharge? YES NO
 Associated with itching or burning? YES NO
 Associated with unusual odor? YES NO
 Do you get yeast infections? YES NO
 Do you experience pain during intercourse? YES NO
 Is the pain mostly external or internal? _____

Do you have a gynecologist? YES NO
 When was your last pap smear? _____ Result? _____
 Have you ever had an abnormal pap? YES NO
 If yes, what follow up was necessary? _____
 Have you ever had a mammogram? YES NO

Have you ever had a sexually transmitted disease?
 Chlamydia, Gonorrhea, Herpes, Other: _____
 When? _____ Was it treated? _____

Do you experience milk or other discharge from your nipples? YES NO
 Have you ever used an IUD? YES NO
 Have you ever used the Oral Contraceptive Pill YES NO
 If yes, for how long? _____ When did you last use it? _____
 How long did it take for your menses to regulate? _____

Please indicate number of:

___Pregnancies	___Premature Births
___Children	___Ectopic Pregnancies
___Miscarriages	___IVF's
___Abortions	___IUI's

Fill out this section if applicable

Previous Gynecological Surgeries:	Date of Procedure
C-Section Births	_____
Dilation & Curettage (D&C)	_____
Hysterosalpingogram (HSG)	_____
Hysteroscopy	_____
Laparoscopy	_____
Other:	_____

Previous Diagnostic Assessments: *(please check all that apply)*

<input type="checkbox"/> Advanced Maternal Age	<input type="checkbox"/> Menorrhagia
<input type="checkbox"/> Amenorrhea	<input type="checkbox"/> Ovarian Cyst
<input type="checkbox"/> Anovulation	<input type="checkbox"/> Ovarian Hyperstimulation Syndrome (OHSS)
<input type="checkbox"/> Cervical Stenosis	<input type="checkbox"/> Pelvic Adhesions
<input type="checkbox"/> Elevated FSH	<input type="checkbox"/> Pelvic Inflammatory Disease (PID)
<input type="checkbox"/> Endometriosis (mild, moderate, severe)	<input type="checkbox"/> Phospholipid Antibodies
<input type="checkbox"/> Fallopian Tube Blockage	<input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS)
<input type="checkbox"/> Habitual Miscarriage	<input type="checkbox"/> Premature Ovarian Failure
<input type="checkbox"/> Hostile Cervical Mucus	<input type="checkbox"/> Unexplained Infertility
<input type="checkbox"/> Hyperprolactinemia	<input type="checkbox"/> Uterine Fibroids or Polyps
<input type="checkbox"/> Luteal Phase Defect	<input type="checkbox"/> Other: _____

List any fertility drugs you have taken:

Medications you use currently: _____

How long have you been trying to get pregnant? _____

Have you had a fertility workup? YES NO
 What were the results? _____

How is your sexual energy? Low Normal High
 Do you use vaginal lubricants? YES NO

Do you have a stressful occupation? YES NO
 Do you exercise regularly? YES NO
 How often? _____

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

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

Overall Symptoms: *(Please circle any of the following symptoms that currently pertain to you)*

Body Temperature (Kidney & Organ System)

Cold hands	Hot body temperature	Profuse perspiration	Perspire easily
Cold feet	Cold body temperature	Lack of perspiration	Cold hips/buttocks
Sweaty palms	Afternoon Flushing	Night sweating	Incontinence
Sweaty feet	Hot Flashes	Strong thirst	Night time urination

Low back weakness or pain	Vaginal dryness
Fertile cervical mucus	Dizziness
Dark circles around your eyes	Ringing in your ears Low
back pain before your period	Low libido
Feet cold, especially at night	Early morning loose stools
Cold sensation w/menstrual cramps	Premature gray hair
Colder than those around you	

Spleen Function

Energy level:	High	Normal	Low
Poor appetite		Feel heavy/sluggish	Energy lower after a meal
Heaviness in the head		Feel bloated after eating	Poor circulation
Crave sweets		Varicose veins	Bruise easily
Loose stools		Tired around ovulation	Spot before your period comes
Abdominal pain		Tired around menstruation	Nose cold
Indigestion		Nausea	Gas
Often sick		Hypoglycemia	

Stomach Function

Stomachache	Stomach ulcer	Acid reflux	Heartburn
Belching	Hiccups	Mouth ulcers	Bleeding Gums
Ravenous appetite	Bad breath	Nausea	Vomiting

Blood Function (liver, spleen, and heart system)

Menses scanty or late	Difficulty concentrating
Dry skin	Fainting
Chapped lips	Blurry vision
Weak or brittle nails	Poor night vision
Losing head hair	Hair dry/brittle

Heart Function

Heart palpitations	Forgetfulness	Hot hands
Anxiety	Depression	Hot feet
Mental restlessness	High blood pressure	Rapid heartbeat
Chest pain	Heart murmur	Restless dreams
Hemophilia	Tongue ulcers	Insomnia
Manic moods	Speech impediment	Arrhythmia
Severe shyness	Low blood pressure	Wake up in the early am

Lung Function

Persistent cough	Chronic allergies	Dry or flaky skin
Nose bleeds	Nasal dryness	Sneezing
Difficulty breathing	Sinus congestion	Sore throats
Wheezing	Cigarette smoking	Allergies

If you are a smoker, how many cigarettes per day? _____
 How long have you been smoking? _____
 If you are a smoker, do you want to quit? YES NO
 Level of determination to quit: 1 2 3 4 5 6 7 8 9 10

Bowel Function and Elimination

Loose stools	Constipation	Difficulty moving bowels
I.B.S or colitis	Diarrhea	Blood in stools
Small, hard, dry stools	Crohn's disease	Incomplete stools
Mucus in stools	Less than 1 BM/Day	Eating disorder

Accumulated Dampness

Mental fogginess	Swollen hands	Edema in the legs
Mental sluggishness	Swollen feet	Edema in the abdomen
Poor mental focus	Joint stiffness/ache	Chest congestion
Heaviness of the head, the limbs or of the whole body		

Liver and Gallbladder Function

Chest pain	Irritability	Depression	Skin rashes
Chest tightness	Easy to anger	Pain in the ribcage	Acne
All over body tension	Easily frustrated	Headaches	Muscle spasms
Convulsions	Chronic neck tension	Migraines	Muscle cramps
Numbness/tingling	Shoulder tension	Gall stones	Lump in throat
Eye dryness	Seizures	Ring in the ears	PMS
Breast tenderness	Nipple pain	Painful periods	
Wake with bitter taste in mouth		Difficulty falling asleep at night	
Alternating diarrhea and constipation		Easily overwhelmed by stressful circumstances	

Urinary Function

Normal color	Reddish color	Small amount	Dribbling
Dark yellow	Cloudy	Large amount	UTI
Clear color	Strong odor	Very frequent	Pain/burning urination

Frequency: _____ times at night
 _____ during the day
 Urgency: _____

Libido Function

Normal	Diminished sex drive	Lack of desire
High sex drive	Sexual addiction	

Acetylcholine Receptor Antagonist – Antimuscarinic Agents

Atropine, Ipratropium, Scopolamine, Tiotropium

Acetylcholine Receptor Antagonist - Ganglionic Blockers

Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan

Acetylcholinesterase Reactivators

Pralidoxime

Acetylcholine Receptor Antagonist - Neuromuscular Blockers

Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, Uccinylcholine, Tubocurarine, Vecuronium, Hemicholine

Agonist Modulator of GABA Receptor (benzodiazepines)

Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSom, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax, Restoril, Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazepines)

Ambien, Sonata, Lunesta, Imovane

Cholinesterase Inhibitors (irreversible)

Echotiophate, Isoflurophate, Organophosphate Insecticides, Organophosphate-containing nerve agents

Cholinesterase Inhibitors (reversible)

Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Erophonium, Neostigmine, Phystigmine, Pyridostigmine, Carbamate Insecticides

Dopamine Reuptake Inhibitors

Wellbutrin (Bupropion)

Dopamine Receptor Agonists

Mirapex, Sifrol, Requip

D2 Dopamine Receptor Blockers (antipsychotics)

Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, Iuanxol, Clopixol, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydys, Seroquel, Geodon, Solian, Invega, Abilify

GABA Antagonist Competitive binder

Flumazenil

Monoamine Oxidase Inhibitor (MAOI)

Marplan, Aurorix, Maneric, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

Noradrenergic and Specific Sertonegic Antidepressants (NaSSaa)

Remeron, Zispin, Avanza, Norset, Remergil, Axit

Selective Serotonin Reuptake Inhibitor

Paxil, Zolof, Prozac, Celexa, Lexapro, Luvox, Cipramil, Emocal, Serpam, Seropram, Cipralax, Esteria, Fontex, Seromex, Seronil, Sarafem, Fluctin, Faverin, Seroxat, Aropax, Deroxat, Rexetin, Xentor, Paroxat, Lustral, Serlain, Dapoxetine

Selective Serotonin Reuptake Enhancers

Stablon, Coaxil, Tatinol

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despramine, Duloxetine

Tricyclic Antidepressants (TCAs)

Elavil, Endep, Tryptanol, Trepiline, Asendin, Asendis, Defanyl, Demolox, Moxadil, Anafranil, Norpramin, Pertofrane, Prothiadin, Thanden, Adapin, Sinequan, Trofranil, Janamine, Gamamil, Aventyl, Pamelor, Opipramol, Vivactil, Rhotrimine, Surmontil

Date last menses began /

Is your menstrual cycle: Regular ___ Irregular ___

How old were you when you had your first menstruation?	How many days do you bleed in total? /
	Menstrual cycle length (i.e. 26-30 days) /

Describe your flow: Heavy ___ Light ___ Average ___ **Consistency of blood:** Watery ___ Thick ___ Average ___
Does your blood contain clots? Yes ___ No ___ ...and... **At which point during the cycle?** Start ___ Mid ___ End ___
Describe the color of your blood: (red, dark red, brown, purple, brownish red, bright red, pink, etc)

Do you experience menstrual pain? Yes ___ No ___	Before menses ___ During _____ (please specify which days) After ___
What relieves the pain?	Stabbing ___ Cramping ___ Dull ___ Heavy ___ On/off ___

Do you experience pre-menstrual symptoms (PMS)? Please check all that apply.

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

Please list any other pre-menstrual symptoms

Do you ovulate on your own? Yes ___ No ___ What Day? _____	Do you chart your cycle? (circle) 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 mucus around ovulation? Yes ___ No ___	

How many times have you been pregnant? _____ **How many times have you given birth?** _____
 Ages of children _____ Sex of children _____ Given names _____
 Have you had any miscarriages? Yes ___ No ___
 If yes, how many, at how many weeks pregnant, and in what year(s)? _____

 How many times have you had a D&C preformed? _____
 How many abortions have you had? _____ In what year(s)? _____
 Were there any problems that occurred during these pregnancies? _____

<p>Have you ever been diagnosed with:</p> STD? Yes ___ No ___ Pelvic inflammatory disease? Yes ___ No ___ Uterine fibroids? Yes ___ No ___ Polyps? Yes ___ No ___ Pelvic adhesions? Yes ___ No ___ Prolapsed uterus? Yes ___ No ___ Unique shape of uterus? Yes ___ No ___ Endometriosis? Yes ___ No ___ PCOS (polycystic ovarian syndrome)? Yes ___ No ___	Date of last pap smear: _____/_____/_____ (dd/mm/yyyy) Have you ever had an abnormal pap smear? Yes ___ No ___ 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 ___ If answered yes, list STDs: _____
--	--

Do you experience vaginal discharge? Yes ___ No ___
If yes, what colour?
 White ___ Yellow ___ Green ___ Pinkish ___ Red ___
If yes, what consistency?
 Watery / thin ___ Thick ___ Sticky ___
If yes, does it have foul odour? Yes ___ No ___

Have you taken oral contraceptives? Yes ___ No ___
If yes, for how long? _____
When did you stop? _____
Have you ever had an IUD? Yes ___ No ___
Have you ever taken Depo-Provera? Yes ___ No ___

Have you had any hormone testing done? (e.g., Day 3, Day 21)			
FSH	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High
Estrogen (E2)	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High
Progesterone	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High
Prolactin	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High
Thyroid (TSH)	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High
Testosterone	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High
Other: _____	<input type="checkbox"/> Low	<input type="checkbox"/> Normal	<input type="checkbox"/> High

Do you currently have a partner? Yes No
 If yes, what is your partner's name? _____ Age? _____
 Are you married or living together? _____ For how long? _____
 Is your partner supportive of your wishes to conceive? _____

How long have you been trying to conceive? _____

Do you have a family history of infertility (mother, father, grandparents, aunt, uncle, siblings)? _____
 If yes, which family members? _____ Diagnosis? _____

Have you had a Western medical diagnosis relating for fertility? Yes No
 If yes, what was the diagnosis? _____ Who made the diagnosis? _____

Has your partner (if applicable) had a Western medical diagnosis relating to fertility? Yes No
 If yes, what was the diagnosis? _____ Who made the diagnosis? _____

Have you taken medication to help you ovulate? Yes No
 If yes, what kind? _____ For how many cycles? _____

Have you had your uterine/fallopian tubes evaluated medically (HSG)? Yes No
 What were the results? _____

Have you had any tubal operations? Yes No

Have you ever undergone assisted reproductive treatments? (IUI, IVF, ICSI superovulation, etc) Yes No

Month/Year	Type of treatment	Clinic	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What was your medical response to the fertility treatments? Poor Average Good

Are you using donor sperm? Yes No
 If yes, why? (no partner, female partner, male partner has semen issues, etc.) _____

Are you using donor eggs or embryos? Yes No

How is your sexual desire (mental interest)?..... Low Normal High
 How is your sexual arousal (physical/orgasm)?..... Low Normal High
 Do you use vaginal lubricants?..... Yes No
 Have you been exposed to or received chemotherapy or radiation? ... Yes No
 Do you have excessive facial or body hair? Yes No
 Do you have excessively oily skin? Yes No

On your journey toward parenthood, what expectations do you have of AK-U-Puncture Global Wellness Inc.? Please list the wellness goals you wish to obtain here:

Please consider letting us know what you need most from us during our time together (check as many as you wish):

- Perspective** (provide a fresh or different way of looking at a situation)
- Validation** (provide encouragement and acknowledgement)
- Message** (share fitting knowledge, opinions, or wisdom)
- Energy** (provide positive energy and support)
- Advice** (provide recommendations and suggestions)
- Feedback** (offer observations, insight, ideas, and opinions)
- Solutions** (share solutions to problems or issues)
- Plan** (co-develop a plan of action with you)
- Structure** (provide support and a check-in structure for you)
- Challenge** (provide a challenge to you to stretch or make a change)
- Tough love** (when necessary, have the conversations you may least want to have)
- Resource** (suggest/refer you to experts, books, tools, assessments)
- Caring** (provide listening, patience, safety, and love)
- Removed** (you may just want to come and relax, nothing more)

If there is anything else you would like us to know about you in order to make your experience here better, please share it here:

Patient Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

While acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall well being, practitioners 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, your practitioner 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 your acupuncturist if worsening of symptoms continues for more than 2 days;
- Fainting can occur in certain patients, particularly at the first treatment.

Is there anything your practitioner 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;

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.

- If you have a bleeding disorder;
- If you are taking anti-coagulants (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. At this clinic we use single-use, sterile, disposable needles. However, although rare, significant complications have been reported in the literature and we need to make you aware. These include pneumothorax, perforation of an internal organ, infection, and nerve damage. We are rigorously trained in safe needle techniques, thus these complications have never been a case in our practice. If you have any questions or concerns in this regard, do not hesitate to speak with your practitioner about it.

I have read and agreed to the terms outline above _____ (initial)

Date _____



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Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time.

I wish to rely on my practitioner to exercise judgment during the course of treatment, which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, 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 further conditions for which I seek treatment.

Privacy Policy

The information received and collected about our clients/patients from their visit to AK-U-Puncture Global Wellness Inc. is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by AK-U-Puncture Global Wellness Inc., unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of AK-U-Puncture Global Wellness Inc. (also, AK-U-Puncture Global Wellness Inc. will not give, share, sell, or transfer any personal information to a third party unless required by law). Under absolutely no circumstances would this communication happen without the signed consent of the client/patient. The client/patient information will be stored both in digital and hard copy format on AK-U-Puncture Global Wellness Inc. premises. On occasion, AK-U-Puncture Global Wellness Inc. may use client/patient information to conduct clinical studies to help us improve upon services provided.

Appointment Policy

Welcome to AK-U-Puncture Global Wellness Inc. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy.

Many of our clients are pleased to find out that we are usually on time. This is because **a treatment room has been reserved for you**, whereas most medical offices overbook by appointing several patients at the same time. That kind of scheduling provides the practitioner with a steady flow of patients but does not respect the patient's time.

Occasionally, there is a problem with patients who are not used to staying on schedule themselves. With that in mind, if you are going to be more than 15 minutes late, please call to confirm availability. A minimum of 24 hours notice is required to reschedule or cancel appointments. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand most insurance companies do not reimburse for missed sessions. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

Print name in full

(Print name of representative if represented by another)

Signature

(Signature of Representative)

Date



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Patient Information Release Request Form

I, _____ (please print name) understand that as part of AK-U-Puncture Global Wellness Inc.'s effort to provide me with the highest standard of integrated care, they may consult freely with other physicians and healthcare professionals, whose care I am under, regarding any of my medical treatments or relevant information. This could include the exchange of both verbal and written communications (including lab work).

I give full consent so that AK-U-Puncture Global Wellness Inc. may share personal information and my confidential treatment plan with my other healthcare providers to better my care. _____ (Initial)

(to be filled out by your AK-U-Puncture Global Wellness Inc. practitioner)

The following is an authorization to provide AK-U-Puncture Global Wellness Inc. with the following information:

- All recent lab work results
- All medical records
- All semen tests
- Other: _____

Medical Services Plan (MSP) #: _____

Doctor's Name: _____ Clinic Name: _____

Clinic Phone #: _____ Clinic Fax #: _____

I am nineteen years of age or older:

- Yes
- No

Client/Patient Signature: _____ Date: _____

Signature of parent or guardian (if applicable): _____

Thank-you for your prompt attention to this request. If you have any questions, please feel free to call us at (949) 424-8956 or email drkelly@acupunctureoc.com

AK-U-Puncture Global Wellness Inc.