MAMA LOUNGE
2001 PINE STREET SAN FRANCISCO, CA 94115 (415) 857-3228 MAMALOUNGESF.COM

Female Fertility Questionnaire

Name (Last, First) _____ Age_____ Date_____

Birth Date _____ /_____ /_____ Address: _____

City: _____ State: _____ Zip: _____ Phone(cell)_____

E-mail address: _____

How did you hear about Mama Lounge? Friend – (who?) _____

Internet _____ MD/Midwife _____ Other _____

Emergency Contact: _____ Relation: _____Phone #: _____

Regular Medical Doctor: _____

Fertility Specialist / Clinic: _____

Occupation: _____ Employer: _____

General Questions

Have you ever had acupuncture before? Y N

Are you now or could you be pregnant? Y N

Date of conception_____

Do you have a history of miscarriage? Y N

Do you have a pacemaker, heart arrhythmia, or other heart condition? Y N

Have you ever had blood-clotting problems or problems with bleeding? Y N

Are you on blood thinning medications? Y N

Do you take aspirin regularly? Y N

Have you ever been diagnosed with Hepatitis? HIV? AIDS? TB? Y N

If so, when?_____

Surgical History: Please list all surgeries and approximate age:

_____

_____

Hospitalizations and approximate date:

_____

Specific allergies and reaction:

_____

Major Accidents/Injuries (include head injuries, fractures, deep cuts, serious sprains, etc.) Indicate date or age:

_____

Were there any abnormal or memorable conditions surrounding your birth:

_____

Family Medical History (any medical conditions that run in your family):

Diabetes Who_____

Cancer Who_____

High Blood Pressure Who_____

Heart Disease Who_____

Stroke Depression/Mental Illness Who_____

Alcoholism/Drugs Who_____

Other_____ Who_____

Medication History

Have you taken oral contraceptives? Yes No When? _____ How long? _____

Have you taken medication to help you ovulate? Yes No When? _____ How long? _____

List all **medications and supplements** you are currently taking:

RX: _____ Dosage:_____Date Started:_____

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RX: _____ Dosage:_____Date Started:_____

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RX: _____ Dosage:_____Date Started:_____

Well-Woman History

Have you ever had an abnormal pap smear? Yes No

Have you ever had a cervical biopsy, operation, cauterization or conization? Yes No

Have you ever had a venereal disease? Yes No What kind?_____

Do you get yeast infections regularly? Yes No

Do you have chronic vaginal discharge? Yes No

Do you douche regularly? Yes No With what?_____

Do you use vaginal lubricants? Yes No Which Ones?_____

Do you use tampons? Yes No Do you sleep with one in? Yes No

Do you ever experience pain with sex? Yes No

Age at which menses began _____ menses stopped _____

Are your periods painful? Yes No

How many days do you normally bleed? _____

How heavy is the bleeding? Light Normal Heavy

What color is the blood? Light red Red Dark red Purple Brown Black

Is there clotting? Yes No

Does your face break out before or during your period? Yes No

Do your breasts become tender when you are premenstrual? Yes No

Do you get premenstrual low back pain? Yes No

Do you bleed or spot between periods? Yes No

How many days are there from one period to the next? _____

Date of last menstrual period _____

Have your cycles changed since they began? Yes No

Do you ovulate on your own? Yes No On what day of your cycle? _____

Do your breasts become tender at ovulation? Yes No

Do you experience pain at ovulation? Yes No

Do your bowel movements become loose at the beginning of your period? Yes No

Have you ever been diagnosed with uterine fibroids or polyps? Yes No

Have you ever had pelvic inflammatory disease? Yes No Were you treated for it? Yes No

Have you ever been diagnosed with endometriosis? Yes No

Have you been diagnosed with pelvic abnormalities? Yes No

Have you had surgeries besides a D&C? Yes No When?_____ What kind?_____

How many pregnancies have you had? _____

How many children do you have? _____

Were there complications during your pregnancies? Yes No If yes, what?_____

How many abortions have you had? _____

How many miscarriages have you had? _____

How many times has a D & C been performed? _____

Fertility Treatments

Have you had fertility treatments? Yes No

If yes, when and where?_____

By whom? _____

What types? _____

Have you had a diagnosis relating to infertility? Yes No What was it? _____

Have your fallopian tubes been evaluated medically? Yes No What were the results? _____

Have you had any tubal operations? Yes No

Do you have a single partner with whom you have been trying to conceive? Yes No — Male Female Other

Semen Analysis Results _____ Other Labwork or Diagnostics _____

Is your partner supportive of your wish to conceive? Yes No

How long have you been trying to conceive? _____

How is your sexual energy? Low Normal High

Have you ever had an Autoimmune or Thyroid diagnosis? _____

Have you had any hormone laboratory tests performed? Yes No

Cycle Day 3 Results: _____ Progesterone (Day 21): _____

Other: _____

General Health

Are you more than 20% over your ideal body weight? Yes No

Are you more than 20% below your ideal body weight? Yes No

Do you have a stressful occupation? Yes No

Do you exercise regularly? Yes No

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

Have you been exposed to any known environmental toxins or hormones? Yes No

Was your mother exposed to DES when she was pregnant with you? Yes No

Eastern Diagnosis

Answer YES or NO to each of the following questions. Don't worry about what the symptoms mean; just note whether you experience them. If you have more than one-fourth to one-third YES responses in any diagnostic category, then you may have an element of this imbalance in your system. It is common to have this occur in more than one category. This **DOES NOT** mean that you have problems with the organs themselves.

Kidney Yin Deficiency

Do you have lower back weakness, soreness, or pain, or knee problems? Yes No
Do you have ringing in your ears or dizziness? Yes No
Does your hair prematurely gray? Yes No
Do you have vaginal dryness? Yes No
Is your midcycle fertile cervical mucus scanty or missing? Yes No
Do you have dark circles around or under your eyes? Yes No
Do you have night sweats? Yes No
Are you prone to hot flashes? Yes No
Would you describe yourself as afraid a lot? Yes No
Does your tongue lack coating? Does it appear shiny or peeled? Yes No

Kidney Yang Deficiency

Do you have premenstrual low back pain? Yes No
Is your low back sore or weak? Yes No
Are your feet cold, especially at night? Yes No
Are you typically colder than those around you? Yes No
Is your libido low? Yes No
Are you often fearful? Yes No
Do you wake up at night or early in the morning because you have to urinate? Yes No
Do you urinate frequently, and is the urine diluted and/or profuse? Yes No
Do you have early morning loose, urgent stools? Yes No
Do you have profuse vaginal discharge? Yes No
Does your menstrual blood tend to be dull in color? Yes No
Do you feel cold cramps during your period that respond to a heating pad? Yes No
Is your tongue pale, moist, and swollen? Yes No

Spleen Qi Deficiency

Are you often fatigued? Yes No
Do you have poor appetite? Yes No
Is you energy lower after a meal? Yes No
Do you feel bloated after eating? Yes No
Do you crave sweets? Yes No
Do you have loose stools, 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 feeling heavy or sluggish? Yes No
Are you prone to feeling heaviness or grogginess in the head? Yes No
Do you bruise easily? Yes No
Do you think you have poor circulation? Yes No
Do you have varicose veins? Yes No
Are you lacking strength in your arms and legs? Yes No
Are you lacking in exercise? 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 your menstruation thin, watery, profuse or pinkish in color? 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 your menstrual cramps accompanied by a bearing-down sensation in your uterus? Yes No
Are you often sick, or do you have allergies? Yes No
Have you been diagnosed with hypothyroid or anemia? Yes No
Do you have hemorrhoids or polyps? Yes No
Does your tongue look swollen, with teeth marks on the sides? Yes No
Do you have a pale, yellowish complexion? Yes No

Blood Deficiency (not necessarily equated with anemia)

Are your menses scanty and/or late? Yes No
Do you have dry, flaky skin? Yes No
Are you prone to getting chapped lips? Yes No
Are your fingernails or toenails brittle? Yes No
Are you losing hair on your head (not in patches, but all over)? Yes No
Is your hair brittle or dry? Yes No
Do you have diminished nighttime vision? Yes No
Do you get dizzy or light-headed around your period? Yes No
Are your lips, the inner side of your lower eyelids, or tongue pale in color? Yes No

Blood Stasis

Is your menstrual flow ever brown or black in color? Yes No
Do you feel midcycle pain around your ovaries? Yes No
Do you have painful, unmovable breast lumps? Yes No
Do you experience periodic numbness of your hands and feet (especially at night)? Yes No
Do you have varicose or spider veins? Yes No
Do you have red hemangiomas (cherry red spots) on your skin? Yes No
Does your complexion appear dark and "sooty"? Yes No

Do you have chronic hemorrhoids? Yes No
Does your menstrual blood contain clots? Yes No
Have you been diagnosed with endometriosis or uterine fibroids? Yes No
Is your lower abdomen tender to palpation (resisting touch)? Yes No
Can you feel any abnormal lumps in your lower abdomen? Yes No
Do you have piercing or stabbing menstrual cramps? Yes No
Does your tongue look dark? Yes No
Do you have dark spots on your tongue? Yes No
Are the veins beneath your tongue twisty and tortuous? Yes No
Do you have dark spots in your eyes? Yes No
Have you been diagnosed with any vascular abnormality or blood clotting disorder? Yes No

Liver Qi Stagnation

Are you prone to emotional depression? Yes No
Are you prone to anger and/or rage? Yes No
Do you become irritable premenstrually? Yes No
Do you feel bloated or irritable around ovulation? Yes No
Does it feel as if your ovulation lasts longer than it should? Yes No
Are your breasts sensitive/sore at ovulation? Yes No
Do you experience nipple pain or discharge from your nipples? Yes No
Do you have a lot of premenstrual breast distension or pain? Yes No

Have you been diagnosed with elevated prolactin levels? Yes No

Do you become bloated premenstrually? Yes No
Are your pupils usually dilated and large? Yes No
Do you have difficulty falling asleep at night? Yes No
Do you experience heartburn or wake up with a 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 your menstrual blood thick and dark, or purplish in color? Yes No
Is your tongue dark or purplish in color? Yes No

Heart Deficiency

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
Is the tip of your tongue red? Yes No
Is there a crack in the center of your tongue that extends to the tip? Yes No
Do you sweat excessively, especially on your chest? Yes No

Excess Heat

Is your pulse rate rapid? Yes No

Is your mouth and throat usually dry? Yes No

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

Do you often feel warmer than those around you? Yes No

Do you wake up sweating or have hot flashes? Yes No

Do you break out with red acne (especially premenstrually)? Yes No

Do you have a short menstrual cycle? Yes No

Do you have vaginal irritation or rashes? 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 stringy tissue or mucus? Yes No

Are you prone to yeast infections and vaginal itching? Yes No

Do your joints ache, especially with movement? Yes No

Are you overweight? Yes No

Do you have a wet, slimy tongue? Yes No

Damp Heat

Do you have signs of heat and/or dampness as indicated above? Yes No

Do you have foul-smelling, yellow, or greenish vaginal discharge? Yes No

Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase? Yes No

Cold Uterus

Do you fit the Kidney Yang deficiency category (50% or more answered Yes)? Yes No

Do you fall into the Blood stasis pattern (50% or more answered Yes)? Yes No

Does your lower abdomen feel cooler to the touch than the rest of your trunk? Yes No

Patient Informed Consent to Care and Treatment

Acupuncture Consent to Treat

1. I, _____, hereby authorize the licensed acupuncturist at Mama Lounge to administer any style of Chinese Medicine relevant to my diagnosis and treatment, including but not limited to the following:

- Insertion of disposable, stainless steel acupuncture needles of various sizes into my body at different depths and locations.
- Heated moxibustion treatment using the herb Artemisia Vulgaris, or a heat lamp may be placed on or near any part of my body. There is also indirect moxibustion treatment where the herb may rest on the skin. The heat might cause slight discomfort or leave a small scar or blister on the skin. With any type of heat, there is risk of burn.!
- Vigorous massage called "gua sha" or regular massage that may produce redness, tenderness or slight bruising of the skin,
- Cupping may be used to promote circulation. Suction from the cups may produce red or purple bruising.
- Electrical Stimulation may be used to enhance the treatment at various acupuncture points.

2. I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases, dizziness or fainting. Although rare, there have been reports of nerve damage and organ puncture connected to acupuncture treatment. Infection is also a possible risk. However, I understand that this office uses only sterile disposable single-use needles, and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

3. The herbs and nutritional supplements used in Chinese Medicine are considered safe but may have potential side effects. I understand that some herbs may be toxic at large doses, and some herbs may be inappropriate to take during pregnancy. I will notify the licensed acupuncturist at Mama Lounge if I am or become pregnant. I will notify the licensed acupuncturist at Mama Lounge immediately if I notice any unanticipated or unpleasant side effects associated with the consumption of herbal medicine or nutritional supplements. I do not expect the licensed acupuncturist at Mama Lounge to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her to exercise judgment during the course of treatment to make decisions that are in my best interest, based upon the facts then known.

4. I understand the licensed acupuncturist at Mama Lounge has the right to refuse treatment to any patient at any time. Reasons for refusal of treatment include crude behavior or inappropriate conduct

Massage Consent to Treat

1. I give my permission to receive massage therapy at Mama Lounge

2. I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.

3. I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.

4. I have clearance from my physician to receive massage therapy.

5. I understand the risks associated with massage therapy include, but are not limited to: superficial bruising, short-term muscle soreness, exacerbation of undiscovered injury; I therefore release the company and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.

6. I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.

7. I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so she may adjust accordingly.

8. I understand that I or the massage therapist may terminate the session at any time.

9. I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

Counseling Consent to Treat

1. Confidentiality
All information obtained in the course of the professional service is confidential unless there is a compelling professional reason for its disclosure. Your coach will disclose confidential information without a specific release if it is necessary to prevent foreseeable imminent harm to the client or another. In all circumstances, the coach will be judicious in the amount of information that is disclosed.
Coaches may disclose confidential information without the consent of the client only as mandated or permitted by law. When possible, coaches inform clients about the disclosure of confidential information and possible ramifications before the disclosure is made. Coaches will only disclose confidential information to third parties with the appropriate written consent.

2. Liability
This agreement is for Coaching, not Psychotherapy. Ms. Carol Jones is working only within the capacities of a Coach and will not be held liable for discrepancies. While coaching can work with issues such as identifying and reaching goals, and changing the behaviors that aren't working well for you, coaching will not address psychological issues such as depression and anxiety. For issues such as these, seek the medical attention from a Physician or Licensed Mental Health Professional in your area. By signing this agreement, you are agreeing that you understand the difference in these two functions and you will get appropriate professional help for mental health issues if necessary.

Authorization to Release or Obtain Information

I hereby authorize my provider at Mama Lounge to exchange all pertinent clinical information pertaining to me with other providers in the practice. I hereby release from liability and agree to indemnify and hold forever harmless all persons involved in this exchange of information from any loss, damage, claim or legal action arising out of such exchange of information. I understand these records may include personal and psychological information, and I may withdraw this authorization at any time, except to the extent
that action has been taken on this authorization.

By voluntarily signing below, I show that I have read (or have had read to me) and understand this consent to treatment. I have been told about the risks and benefits of acupuncture/massage/counseling and have had an opportunity to ask questions. This consent form shall cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Signature: _____

Name:_____Date:_____

THANK YOU FOR YOUR COOPERATION IN THOROUGHLY COMPLETING THIS FORM☺