Wu's Healing Center **1014 Clement Street, San Francisco, CA 94118 (415) 750-5050**

Welcome to Wu's Healing Center. Here is a short introduction and orientation to our clinic and services. Please read carefully.

Location: 1014 Clement Street, between 11th and 12th Avenues. The first appointment for the Fertility Program may take up to 3 hours. Subsequent visits are approximately 2 hours. **We ask that you not park at the parking meters, as they last up to two hours and we do not feed them under any circumstance.** Nearby parking is often limited to two hours, which is insufficient for most appointments, **especially your first visit.** The best option is to park south of Geary where unlimited street parking may often be found.

Scheduling: Our goal is to provide quality treatments in a timely manner. In order to do so please follow our appointment/ cancellation policy. The policy enables us to better utilize available appointments for our clients. To cancel or reschedule appointments please call 415-750-5050 at least ***48 hours BEFORE*** your Tuesday's-Friday's appointments and ***72 hours BEFORE*** your Monday's appointments. If you do not reach us you may leave a detailed message on the voice mail.

Insurance: **If you are not sure if your insurance company covers our treatments, please find out *before* your first appointment so that you will know if an insurance receipt will be necessary.** We **do not** accept insurance. However, we will issue you a receipt ***for you to submit*** to your insurance company for reimbursement **ONLY** if you have your diagnosis code from a Western Medical Doctor. Please be sure to give us your diagnosis code upon your initial appointment. Supporting documentation may be required, including a letter of diagnosis. **Insurance receipts will not be issued retroactively, so please be sure to ask for one upon each visit.** Please inform your insurance company to pay any reimbursement checks directly to you, as we do not interact with your insurance company on your behalf.

Before each treatment: Please abstain from alcohol, caffeine and other drugs for 24 hours prior to your appointment. (However, you may take your normal medication, if any). Your stomach should not be empty and not full. If it has been a long time since you have eaten, you should eat a light snack before coming in. **Please do not scrape or brush *your tongue* the evening before or the day of your appointment.**

Fertility client's first appointment: When you visit the clinic for your first treatment, bring the results of any Western medical hormone-level tests (FSH/LH) taken ***within three months*** (if available). For your male partner, please bring any information related to ***sperm count or motility***. **NOTE: ALL MALE FERTILITY PATIENTS MUST CALL TO SCHEDULE THEIR OWN APPOINTMENT. ALL NEW PATIENTS WILL RECEIVE ORGAN ACUPRESSURE, MERIDIAN ACUPRESSURE AND ACUPUNCTURE ON THEIR 1ST VISIT.**

For your first visit:

- A practitioner will interview you to ascertain your specific concerns and gather pertinent information about your general health from the perspective of Chinese Medicine. You will also receive acupressure from our practitioners, including Chi Organ Acupressure and Chi Meridian Acupressure, as directed by Dr. Wu after she reviews your chart, which may vary with each appointment. Note: There is no pre-treatment consultation, and you will **NOT** see Dr. Wu until **AFTER** your acupressure.
- After you have received your acupressure, you will receive acupuncture from Dr. Wu. If you have any questions, this is the time to ask them so please have your questions as concise as possible. You may also e-mail your list of questions prior to your appointment so that they may be addressed during your visit
- Dr. Wu will usually prescribe herbs for you to take at least until your next visit. She may also strongly recommend avoiding or consuming certain foods. The herbs and eating/drinking recommendations are specific to each person. These will be explained to you after your treatment.

IVF/IUI (ARTs): If you are undergoing any **Assisted Reproductive Technologies (ARTs),** such as **In Vitro Fertilization (IVF)** or **Intrauterine Insemination (IUI),** Dr. Wu's Fertility Program can increase the effectiveness of your Western procedure and can reduce the side effects of any drugs and/or hormones prescribed to you.

Costs: **Prices shown are per person.** Payment may be made in the form of cash, check, Visa or MasterCard and must be paid at the time services are rendered. Please bring a method of payment to each visit to avoid any unnecessary delays to your treatment.

FERTILITY PROGRAM AND REPRODUCTIVE ISSUES:

Treatments	1st Visit	Subsequent Visits
Acupuncture (diagnosis included)	$225	$175
Chi Organ Acupressure	$120	$120
Chi Meridian Acupressure	$ 80	$ 80
Total cost	$425	$375

Weekly treatments are usually recommended.

NOTE: ALL MALE FERTILITY PATIENTS WILL RECEIVE ORGAN ACUPRESSURE, MERIDIAN ACUPRESSURE AND ACUPUNCTURE ON THEIR 1ST VISIT.

GENERAL HEALTH AND OTHERS:

Treatments	1st Visit	Subsequent Visits
Acupuncture (diagnosis included)	$225	$175
Chi Organ Acupressure	$120	$120
Chi Meridian Acupressure	$ 80	$ 80
Total cost	$425	$375

NOTE: ALL NEW PATIENTS WILL RECEIVE ORGAN ACUPRESSURE, MERIDIAN ACUPRESSURE AND ACUPUNCTURE ON THEIR 1ST VISIT.

HERBS: Any herbs that are prescribed are an additional cost. Herbs cost an average of $25.00 each per week. Please be aware that you may be prescribed an average of three to six herbs and in some cases more depending on your specific diagnosis.

PRE-NATAL CLIENTS: The benefits of Dr. Wu's fertility treatment guidelines, include: less tiredness, increased vitality, fewer emotional outbursts, greater calmness, less nausea, a normal appetite, a tremendous decrease in miscarriages, and full-term pregnancies.

Dear Clients and Potential Clients of Wu's Healing Center:

For over thirty years of clinical practice, Dr. Angela C. Wu has questioned long standing beliefs prevalent in Traditional Chinese Medicine and tested new cutting edge approaches, the foremost being needling pregnant women, something traditional acupuncturists, restrained by centuries of tradition, historically did not do. Her pioneering efforts led to the development of a successful and effective fertility program. Dr. Wu discovered that the most important aspects for ensuring a healthy pregnancy are lifestyle changes including changing eating and drinking habits. Her comprehensive fertility treatment program includes eating and drinking guidelines, special herbal formulas, and stress reducing techniques designed to maximize your fertility potential.

We would like to remind you that when coming to Wu's Healing Center, you will be treated by Dr. Wu or, in the event of her absence, one of her associates.

The associates closely follow a protocol that has been set up by Dr. Wu and they report all cases to her.

To wait only to see Dr. Wu may delay the appointment to possibly several weeks, as we are a very busy clinic and appointment slots fill quickly.

The Fertility Program consists of several aspects including:

- **Acupuncture**
- **Acupressure**
- **Nutritional Supplements**
- **Eating & drinking guidelines**
- **Home self-practice**

Please avoid the use of ALL SCENTED PRODUCTS, such as BATH OILS, ESSENTIAL OILS, INCENSE, CANDLES, SACHETS, LOTIONS, PERFUMES, etc.

These could cause severe reactions for our clients.

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PLEASE USE BLUE OR BLACK INK ONLY

Last Name: _____ **First Name:** _____
Name you prefer to be called (if different than above): _____
Sex: (circle one) M F Marital Status: _____ **Age:** _____
Birthdate/Time/Place: _____/_____/_____
Address: _____ **City/State/Zip:** _____
Home Phone: _____ **Cell:** _____ **Email:** _____
Emergency contact name: _____ **Emergency contact #:** _____
How did you hear about us? _____ **Your Occupation:** _____
Employed by: _____ **Your doctor's Name:** _____
Your doctor's specialty: _____ **Your doctor's #:** _____
Diagnosis by your doctor: _____
Present Complaints/Reason(s) for visiting our clinic (required): _____
_____
_____
When Developed and How: _____
Treatment Received, If Any: _____ **How Long:** _____
Current Height: _____ **Current Weight:** _____
Blood Type (if known): _____ **Blood Pressure (if known):** _____/_____
Cholesterol (if known) HDL: _____ **LDL:** _____

Please answer the following questions yes or no:

Do you bruise or discolor easily?	____	Are you hungry at this time?	____
Do you bleed for a long time?	____	Are you exhausted at this time?	____
Do you have high blood pressure?	____	Are you nervous at this time?	____
Do you or have you ever had any heart problem?	____	Are you pregnant at this time?	____
Do you have any respiratory problems?	____	Do you have a compensation claim or lawsuit pending your complaint?	____
Have you had any surgery before?	____	Have you had acupuncture before?	____
Are you in therapy at this time?	____	How does your body respond to soft tissue manual therapy? Circle all that apply:	
Are you taking any medications?	____	Improvement, Neutral, Sore, Very Sore, Unknown, Other _____	

I, the undersigned, realize that acupuncture / acupressure may be considered an investigative procedure in the United States of America. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatment. Every attempt will be made to protect me from harm, but there may be the possibility of unfavorable skin reaction, unforeseen nerve damage, possible infection, unexpected bleeding and / or other complications not anticipated. I realize that I may withdraw from the program at any time. **I agree to pay for all services at the time they are received.**

Patient's Signature: _____ **Date:** _____

Age period began: _____

Average number of days in your cycle: _____

Duration of period: _____

Please check appropriate spaces.

Pain/Cramps: _____none _____prior to period _____during period _____after period

Intensity of pain/cramps: _____great _____moderate _____light

Color of menstrual blood: _____light _____medium _____dark

Menstrual flow: _____has clots ____is heavy ____is light _____has fishy odor _____has rotten odor

Non-menstrual bleeding/spotting? _____No _____Yes

Water weight gain/bloating: _____prior to period _____during period _____after period

Other physical / emotional changes related to cycle:
_____

Please indicate how long you have used any of the following birth control methods:

_____Abstinence _____Pill _____Condom _____Condom with foam or jelly

_____Spermicides _____IUD _____Diaphragm _____Diaphragm with foam or jelly

_____Withdrawal _____Rhythm _____Other: _____

Vaginal Discharge: _____No _____Yes Color: _____ Odor: _____

Vaginal infections: _____Past _____Present How treated:_____

Have you ever been pregnant? _____No _____Yes Number of times: _____

Was pregnancy **natural** or with **IVF/IUI**? _____

Number of children living: _____ Year child was born: (1)_____ (2)_____ (3) _____

Condition of newborns: _____ healthy _____ premature _____ jaundice _____ late _____ other

Have you ever miscarried? _____No _____Yes Number of times: _____

Have you ever had an abortion? _____No _____Yes Number of times: _____

Reason(s) _____

Other complications related to pregnancy? _____

Have you gone through menopause? ____Yes _____No If yes, when?_____

Other remarks regarding OB/GYN? _____

_____

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Patient's Symptoms

Patient's Name:_____Date_____

Please tell us your symptoms and whether they are something you've experienced in the **past** or that you are **presently experiencing**. There are some things that many people have experienced at some point in the past, such as a headache. In this case we'd like to know if this was something that was common for you or that you frequently experienced as opposed to a rare, isolated incident.

General

Past / Present

( ) ( ) fatigue
( ) ( ) sleep problems
( ) ( ) swollen glands
( ) ( ) hot or cold intolerance
( ) ( ) frequent headaches
( ) ( ) weight loss
( ) ( ) weight gain
( ) ( ) fever or chills
( ) ( ) allergies
( ) ( ) car accident injury
( ) ( ) knocked unconscious

Nervous System

( ) ( ) dizziness
( ) ( ) blurred vision
( ) ( ) fainting
( ) ( ) paralysis
( ) ( ) tremors
( ) ( ) numbness / tingling
( ) ( ) convulsion
( ) ( ) imbalance
( ) ( ) memory loss
( ) ( ) muscle weakness

Urinary

( ) ( ) painful urination
( ) ( ) frequent urination
( ) ( ) difficulty urinating
( ) ( ) incontinence
( ) ( ) bed wetting
( ) ( ) discolored urine
( ) ( ) frequent infections
( ) ( ) prostate problems
( ) ( ) unusual discharge

Head

( ) ( ) headaches
( ) ( ) entire head
( ) ( ) back of head
( ) ( ) forehead
( ) ( ) temples
( ) ( ) migraine
( ) ( ) head feels heavy
( ) ( ) dizziness
( ) ( ) light headedness
( ) ( ) fainting
( ) ( ) light bothers eyes
( ) ( ) loss of smell
( ) ( ) loss of taste
( ) ( ) loss of balance
( ) ( ) loss of hearing
( ) ( ) loss of memory
( ) ( ) pain in ears
( ) ( ) ringing in ears
( ) ( ) buzzing ears
( ) ( ) concussion/head injury

Neck

( ) ( ) pain in neck
( ) ( ) neck pain with movement
( ) ( ) pinched nerve in neck
( ) ( ) neck feels out of place
( ) ( ) stiff neck
( ) ( ) muscle spasms in neck
( ) ( ) grinding sound in neck
( ) ( ) popping sounds in neck
( ) ( ) arthritis in neck

Emotional

( ) ( ) anxiety or worry
( ) ( ) nervousness
( ) ( ) irritable
( ) ( ) frequent crying
( ) ( ) anger
( ) ( ) tension
( ) ( ) mood swings
( ) ( ) fear
( ) ( ) restlessness
( ) ( ) confusion
( ) ( ) depression
( ) ( ) suicidal

Reproductive system

( ) ( ) painful intercourse
( ) ( ) prostate problems
( ) ( ) birth control methods
( ) ( ) sexual problems
( ) ( ) loss of sex drive
( ) ( ) genital infections

Low back

( ) ( ) low back pain
( ) ( ) pinched nerve in low back

Pain is *worse* with:

( ) ( ) lifting
( ) ( ) stooping
( ) ( ) standing
( ) ( ) sitting
( ) ( ) bending
( ) ( ) coughing

Back

( ) ( ) slipped disk
( ) ( ) low back feels out of place
( ) ( ) muscle spasms
( ) ( ) arthritis

Mid back

( ) ( ) shoulder blades
( ) ( ) sharp stabbing

Pain/mid back

( ) ( ) chest pain
( ) ( ) sharpness of breath
( ) ( ) pain around ribs

Ear/ eye/ nose/ throat

( ) ( ) earache
( ) ( ) ear discharge
( ) ( ) ringing in ears
( ) ( ) hearing loss
( ) ( ) nose bleeds
( ) ( ) hoarseness
( ) ( ) problems swallowing
( ) ( ) sore throats
( ) ( ) jaw tight or sore
( ) ( ) dental problems
( ) ( ) sinusitis
( ) ( ) tonsillitis

Musculoskeletal

( ) ( ) joint swelling
( ) ( ) muscle cramps
( ) ( ) shoulder pain
( ) ( ) tennis elbow
( ) ( ) arm pain
( ) ( ) hand sensations
( ) ( ) loss of grip
( ) ( ) mid back pain
( ) ( ) rib pain
( ) ( ) low back problems
( ) ( ) hip pains
( ) ( ) foot problems
( ) ( ) leg cramps
( ) ( ) knee pain
( ) ( ) ankle weakness
( ) ( ) tingling foot

Shoulders

( ) ( ) pain in shoulder joint
( ) ( ) pain across shoulders
( ) ( ) bursitis
( ) ( ) arthritis
( ) ( ) can't raise arm above shoulder
( ) ( ) over head
( ) ( ) tension in shoulders
( ) ( ) pinched nerve in shoulder
( ) ( ) muscle spasms in shoulders

Arms and hands

( ) ( ) pain in upper arm
( ) ( ) pain in forearm
( ) ( ) pain on hands
( ) ( ) pain in fingers
( ) ( ) pinched nerve in arm
( ) ( ) pins and needles in arms
( ) ( ) pins and needles in fingers
( ) ( ) fingers go to sleep
( ) ( ) hands cold
( ) ( ) pain in finger joints
( ) ( ) arthritis in fingers
( ) ( ) loss of grip strength

Heart/Lung

Past / Present

( ) ( ) chest pain
( ) ( ) high blood pressure
( ) ( ) low blood pressure
( ) ( ) persistent cough
( ) ( ) hard to breathe
( ) ( ) coughing blood
( ) ( ) coughing phlegm
( ) ( ) irregular heartbeat
( ) ( ) varicose veins
( ) ( ) ankle swelling
( ) ( ) heart disease
( ) ( ) heart attack

Gastrointestinal

( ) ( ) change in appetite
( ) ( ) thirst
( ) ( ) nausea
( ) ( ) vomiting
( ) ( ) diarrhea
( ) ( ) constipation
( ) ( ) gas
( ) ( ) hemorrhoids
( ) ( ) gall bladder
( ) ( ) belching
( ) ( ) heart burn
( ) ( ) abdominal pain
( ) ( ) bloody black stools
( ) ( ) indigestion
( ) ( ) liver trouble

Skin

( ) ( ) easy bruising
( ) ( ) dry skin
( ) ( ) itching
( ) ( ) boils
( ) ( ) rashes
( ) ( ) excessive sweat
( ) ( ) hair changes

Hips, legs and feet

( ) ( ) pain in buttocks
( ) ( ) pain in hip joint
( ) ( ) pain down in legs
( ) ( ) pain down both legs
( ) ( ) leg cramps
( ) ( ) pins and needles in hands
( ) ( ) numbness of leg
( ) ( ) numbness of hands
( ) ( ) numbness of toes
( ) ( ) feet feel cold
( ) ( ) cramps in feet
( ) ( ) swollen ankles
( ) ( ) painful joints in toes
( ) ( ) pain in feet

Disease

( ) ( ) diabetes
( ) ( ) gout
( ) ( ) emphysema
( ) ( ) bronchitis
( ) ( ) stomach ulcer
( ) ( ) duodenal ulcer
( ) ( ) gall bladder disease

Disease (cont.)

( ) ( ) kidney stones
( ) ( ) kidney infection
( ) ( ) bladder infection
( ) ( ) sclerosis
( ) ( ) tuberculosis
( ) ( ) cancer
( ) ( ) goiter
( ) ( ) epilepsy
( ) ( ) nervous breakdown
( ) ( ) hepatitis A
( ) ( ) hepatitis B
( ) ( ) hepatitis C
( ) ( ) HIV infection
( ) ( ) gonorrhea
( ) ( ) syphilis
( ) ( ) anemia
( ) ( ) mumps
( ) ( ) rheumatic fever
( ) ( ) German measles
( ) ( ) chicken pox

Yes / No

( ) ( ) any other diseases?

_____

( ) ( ) any communicable diseases?

_____

Allergies

Yes / No

( ) ( ) moxa (mugwort)
( ) ( ) mint
( ) ( ) latex
( ) ( ) pollen
( ) ( ) fungus / mold
( ) ( ) wheat / gluten
( ) ( ) dairy
( ) ( ) egg
( ) ( ) wheat
( ) ( ) shellfish

Please list any other allergies.
(outdoor allergens, food, medications)

_____
_____
_____
_____

Surgical history

Yes / No

( ) ( ) tonsillectomy
( ) ( ) appendix
( ) ( ) hernia operation
( ) ( ) hemorrhoid operation
( ) ( ) stomach operation
( ) ( ) gall bladder operation
( ) ( ) varicose vein operation
( ) ( ) thyroid operation
( ) ( ) prostate operation
( ) ( ) cesarean section
( ) ( ) removal of ovaries
( ) ( ) other

_____
_____

Do you take medication regularly?

If so, what?

_____
_____
_____
_____
_____
_____

Have you ever taken?

( ) ( ) insulin
( ) ( ) cortisone
( ) ( ) thyroid medicine
( ) ( ) male/female hormones
( ) ( ) tranquilizers/sedatives
( ) ( ) birth control pills

Others?

_____
_____
_____
_____

Have you had x-rays of?

( ) ( ) chest
( ) ( ) stomach
( ) ( ) gall bladder
( ) ( ) kidneys
( ) ( ) skull
( ) ( ) colon
( ) ( ) _____

What kinds of supplements are you taking now?

_____
_____
_____
_____

Please list any other information you feel is important for us to know in regard to your health. (Please include your ***family history*** of medical issues such as heart attack, thyroid condition, cancer, etc.)

_____
_____
_____
_____
_____
_____
_____
_____

Dear Clients:
Our goal is to provide quality treatments in a timely manner. In order to do so please follow our appointment/ cancellation policy. The policy enables us to better utilize available appointments for our clients. **If you have any questions, please ask our staff before signing.**

1. **Our cancellation policy is designed to honor your time as well as ours.**
   A. A non-refundable deposit of $60.00 is required at the time of scheduling to secure your first appointment as a new client or a returned client. Wu's Healing Center requires a notice of cancellation a minimum of one week prior to your first scheduled appointment.
   B. To cancel or reschedule all subsequent appointments, please notify Wu's Healing Center at least 48 hours BEFORE your Tuesday's – Friday's appointments and 72 hours BEFORE your Monday's appointments.
   C. Cancellations can be made by calling the front desk during clinic hours. If you do not reach us during normal clinic hours, you may leave a voicemail or email.
   D. The late cancellation fee is the full price of your appointment.

2. **Please arrive on time for your appointment.** If you are late, you will have to wait to be seen until after those clients who have arrived on time, which may result in a delay of up to 1 hour or longer.

3. The unpredictability and urgency of IVF schedules may need an intensified treatment regime. As a result, the schedule may be backed up without prior notice. Please schedule your appointments accordingly. **Your patience and understanding is appreciated.**

4. **Herbs, books and all other products are non-refundable and non-returnable.** Please keep this in mind when purchasing your herbs, as your herb prescription may change during your next visit. We do not mail herbs, so please order enough to last until your next visit, especially if you live outside of San Francisco.

5. **Wu's Healing Center reserves the right to disqualify itself from treating any patient.**

6. **Insurance:** If you are not sure if your insurance company covers our treatments, please find out ***before*** your first appointment so that you will know if an insurance receipt will be necessary. We **do not** accept insurance. However, we will issue you a receipt ***for you to submit*** to your insurance company for reimbursement **ONLY** if you have your **diagnosis code** from a Western Medical Doctor. Please be sure to give us your diagnosis code upon your initial appointment. **Wu's Healing Center does not generate diagnosis codes.** Supporting documentation may be required, including a letter of diagnosis. Insurance receipts will not be issued retroactively, so please be sure to ask for one upon each visit. Please inform your insurance company to pay any reimbursement checks directly to you, as we do not interact with your insurance company on your behalf.

Thank you for your support and cooperation.
We hope that these policies help us to create a positive and
beneficial experience for you each time that you visit our office.

Patient Copy

Please keep this copy for your records.

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Thank you for your support and cooperation.
We hope that these policies help us to create a positive and
beneficial experience for you each time that you visit our office.

I understand that my signature acknowledges that I have read and agree to follow the above policies.

Signature: _____ Date: _____

Wu's Healing Center Copy

PATIENT INFORMATION AND STATISTICS CONSENT FORM

I, _____ (print your name) authorize Wu's Healing Center and members of its Medical Clinic Staff, faculty and students to review my records for the purpose of collecting statistical data or pertinent clinical information for the purposes of research, publication, education and case study review. I give permission and consent to the publication of statistical and/or clinical data obtained from my records. I understand that all patient records are protected by clinic protocols and confidentiality agreements. **I also understand that I will never be identified as the source of this information and that if any particulars of my case are used for the purposes of publication all possible clues to my identity will be disguised or altered unless I so authorize.**

If you ACCEPT the use of your information as described above, please sign below:

I ACCEPT: _____ _____
Patient Signature **Date Signed**

If you DECLINE the use of your information as described above, please sign below:
(Please do not print your name in the above paragraph if you choose this option)

I DECLINE: _____ _____
Patient Signature **Date Signed**