UNION CENTER FOR HEALING
Union Center For Healing Integral, PLLC
Evolutionary Medicine for the Individual and Community

Mercier Therapy Patient Information

This questionnaire is lengthy so please take your time to fill this out this questionnaire. We ask many questions regarding your pelvic health, menses and past experiences. Please fill out as completely as possible as it will help us to provide the best treatment plan possible for Acupuncture and/or Mercier Therapy. Thank you

Date: _____

Name: _____ Date of Birth: _____

Is there another name you prefer? _____

Address: _____ City: _____ State: _____ Zip: _____

Is it ok to contact you via email? Yes: _____ No:_____ Email: _____

Home Phone: _____ Cell: _____ Other: _____

Preferred Gender Pronouns: _____ Marital Status: _____ Occupation: _____

Are there any terms that you prefer for your practitioner to use or not use when referring to yourself or your body that make you feel more comfortable? (Ex: Chest vs Breast tissue) _____

Is there anything else that you think would be useful for your practitioner to know to plan a comfortable and effective session for you? _____

Do you have any questions or concerns about your session? _____

Referred By: _____ Emergency contact & phone#_____

Primary Care Physician: _____ Phone #: _____

Are you currently/within the last year been under the care of your Primary Care Dr.?_____

What conditions? _____

Pelvic Health Questions

Reason for visit: _____

_____

_____

Current Medications: _____

_____

Past & Current Use of Contraceptives:

_____

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Medications taken for Gynecological Issues: _____

Current Supplements: _____

_____

Are you pregnant now? ☐ Yes ☐ No. Are you trying/preparing to conceive? ☐ Yes ☐ No. If yes, how long? ___
At what age did you get your first period: _____ Do you ever bleed or spot between periods? ☐ Yes ☐ No

First date of your last menstrual period:_____ Are your menstrual cycles spaced regularly? ☐ Yes ☐ No

Number of days from start of one period to the start of the next period:_____

Average number of days of flow (not including spotting): _____ Flow is: ☐ Light ☐ Normal ☐ Heavy

Color is: ☐ Pale ☐ Normal ☐ Dark ☐ Bright Red ☐ Brown Blood clots? ☐ Yes ☐ No

Does your period cause you pain or cramping? ☐ Yes ☐ No When? ☐ Before ☐ During ☐ After

Do you get nausea or vomiting with your period? ☐ Yes ☐ No When? ☐ Before ☐ During ☐ After Period

Do you experience any of the following before your period each month?
☐ Irritability ☐ Breast tenderness or swelling ☐ Food cravings ☐ Headaches ☐ Migraines ☐ Mental depression
☐ Water retention/bloating ☐ Cramping ☐ Acne ☐ Low back pain ☐ Other_____

Do your bowel movements become loose at the beginning of your period? ☐ Yes ☐ No
Do you have any vaginal discharge between periods? ☐ Yes ☐ No
Are you temperature charting cycles? ☐ Yes ☐ No, OPK? ☐ Yes ☐ No, Cervical Mucous? ☐ Yes ☐ No

Do you ovulate on your own? ☐ Yes ☐ No ☐ Unknown, On what day do your ovulate?_____

Current complaint of Pelvic Pain?

_____

_____

When during cycle is pain noted?

_____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No Dates and Outcomes: _____
Date of last pap smear? _____ Normal? ☐ Yes ☐ No

Past pelvic or vaginal infections? If yes, when and how treated?

Any yeast infections? ☐ Yes ☐ No When and how Treated?

Current Gynecological Ultrasounds? When and Results:

History of miscarriage or elective abortions? Dates and occurrences:

History of births: # of C-Section ( ), # of Vaginal ( ), Years of Births: _____

History of adoptions? _____ Years adopted and ages _____

Did you experience any Birth Trauma?

Any Gynecological Surgical History? Give Dates and type: -

Have you had trauma to your pelvic area?_____

History of sexual abuse:

Abdominal Surgical History. Give Dates and type:

Frequency of bowel movements: _____

Blood in stool? ☐ Yes ☐ No Mucous in stool? ☐ Yes ☐ No
Stools are: ☐ Formed ☐ Loose ☐ Dry or Pebble ☐ Alternating between loose and constipated

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Intestinal Issues/Complaints:

_____

_____

Urinary Surgical History:

_____

Maternal Family History of: ☐ Infertility ☐ Fibroids ☐ PMS ☐ Endometriosis
☐ Menopause ☐ Menstrual Problems ☐ Cancer (type)_____

Other Family Medical History:_____

Have you had a diagnosis relating to infertility? ☐ Yes ☐ No Dates & Details:_____

Ovulation Medications?

Name of Medication	When	For how long
_____	_____	_____
_____	_____	_____

History of medically assisted fertility cycles (include IUI with or without medication or medication cycle only):

Dates	Type of Treatment	Drugs given	Outcome, notes

History of IVF:

Dates	Drugs given	# Eggs retrieved	#embryos transferred	Outcome, notes

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For cis-male partners, has your partner had a fertility work-up? ☐ Yes ☐ No. If yes, details:

_____

Semen Analysis Date: _____ Results: _____

How is your sexual energy? ☐ Low ☐ Moderate ☐ High

Have you ever had a hysterosalpinogram (HSG) ☐ Yes ☐ No. Details:_____

Have you ever had a LEEP, laparoscopy, cervical biopsy, cauterization, conization? ☐ Yes ☐ No

Details_____

Have you ever been diagnosed with:

Uterine fibroids or polyps?	☐ Yes ☐ No	Endometriosis?	☐ Yes ☐ No
Pelvic adhesions?	☐ Yes ☐ No	Any pelvic abnormalities?	☐ Yes ☐ No
PCOS?	☐ Yes ☐ No	Vulvydynia	☐ Yes ☐ No
Polycystic ovaries?	☐ Yes ☐ No	Other:	

_____

Have you ever had a sexually transmitted illness? ☐ Yes ☐ No _____

Do you have chronic vaginal discharge? ☐ Yes ☐ No

Have you ever had any sores on your genitals? ☐ Yes ☐ No

Have you ever had pelvic inflammatory disease? ☐ Yes ☐ No

Were you treated for it? ☐ Yes ☐ No How?_____

Are you more than 10 pounds over or below your ideal body weight? ☐ Yes ☐ No

Are you presently taking steroids? ☐ Yes ☐ No

Was your mother exposed to DES while pregnant with you? ☐ Yes ☐ No

Do you have excessive facial hair? ☐ Yes ☐ No

Have you experienced excessive loss of head hair? ☐ Yes ☐ No

Do you have excessively oily skin? ☐ Yes ☐ No

Do you have any discharge from your nipples? ☐ Yes ☐ No

Have you experienced menopause? ☐ Yes ☐ No When?

_____

List any current peri or menopausal symptoms:

_____

Are you currently undergoing any type hormone therapy? If so, please explain:

_____

_____

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Do you currently feel disconnected from your pelvis? _____

_____

How would you like to feel in your pelvis? _____

List all other therapies used/currently using for any above conditions: _____

_____

Recent Hormone testing or other lab work? Include a copy or list here: _____

_____

Anything else? _____

_____

General Health Information

Allergies/Intolerances: (Nuts, oils, food, chemical, environmental, drugs, etc.)_____

Exercise

Days per week Length of workout Type of Activity

Diet

Meals per day Snacks

Caffeinated Drinks Alcohol/week

	A lot	Some	A little	None
Veggies/fruit	☐	☐	☐	☐
Meat/seafood	☐	☐	☐	☐
Eggs/nuts/beans	☐	☐	☐	☐
Dairy	☐	☐	☐	☐
Whole grains	☐	☐	☐	☐
White flour carbs	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Fried foods	☐	☐	☐	☐

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Personal History Please check any conditions you have now or have had in the past.

☐ Arthritis	☐ Liver/Gall Bladder Disease	☐ Stroke	☐ Heart Disease
☐ High/Low Blood Pressure	☐ Hypo/Hyperglycemia	☐ Kidney Disease	☐ Bleeding Disorder
☐ Cancer	☐ Diabetes	☐ Allergies	☐ Diverticulitis/IBS
☐ Ulcer	☐ Seizures/Epilepsy	☐ Hepatitis	☐ Raynaud's Disease
☐ Chronic Fatigue	☐ Anemia	☐ Thyroid Disorder	☐ Multiple Sclerosis
☐ Alcoholism	☐ Pregnancy	☐ Chronic Pain Condition	☐ Whooping Cough/TB
☐ Gastritis/Pancreatitis	☐ Asthma	☐ Infertility	☐ Emphysema

Thank you for taking the time to fill this out.
We look forward to working with you to awaken and reclaim your pelvis

Mercier Therapy Informed Consent and Release Form

I understand that Mercier Therapy is a soft tissue visceral manipulation therapy technique used to help and restore the health and general well being of the female pelvis.

I understand the goal of Mercier Therapy pelvic treatment is to decrease adhesions in and around organs, ligaments, muscles, joints, and support structures of the pelvis, abdomen, hips and low back.

I understand that if I experience any pain or discomfort during a session, I will immediately inform the practitioner so that the pressure and/or application may be adjusted to my level of comfort.

I understand that Mercier Therapy should not be construed as a substitute for a medical examination, diagnosis or prescription. I should see a Gynecologist, Reproductive Endocrinologist or other qualified medical specialist for any physical ailment or suspect condition I might have.

I understand that Mercier Therapy is not intended to take the place of medical/surgical intervention and my practitioner, Jennifer Mercier, ND, PhD shall not bear any responsibility for any ill effects should I choose to NOT adhere to my primary doctor's advice.

I understand that the practitioner is not qualified to diagnose, prescribe or treat any emotional or mental distress and nothing said in the course of the session (s) given should be construed as such.

Because Mercier Therapy is contraindicated (should not be done) under certain medical conditions (IUD, Essure, Endometriosis during menses, any

present cancer cells) I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there will be no liability on the practitioners Victoria Summerquist, EAMP, LMP, and Roxane Geller, EAMP, LMP, should I forget.

Supplements recommended or suggested to me are taken/ingested by my choice/decision. I will not hold the above noted practitioners responsible nor liable should I have an adverse or allergic reaction.

I understand that most of the supplements should be discontinued at the first determination of pregnancy.

I understand the remainder of treatment sessions will resume post partum should I conceive during the program.

I will honor all office policies including but not limited to payment, cancellation notice, tardiness, and conduct. I understand refunds are not given for any reason.

I understand compliance is necessary for successful treatment progress and results. I understand there is no guarantee of pelvic cure or pregnancy.I have read, fully understand, and agree to the above terms and conditions

I understand that Mercier Therapy is not appropriate with: IUD, Tubal clips, Surgical mesh, Cancer, and Pregnancy. Mercier is also contraindicated with Endometriosis during the menstrual cycle. All other times during the cycle are fine. If you have any questions or concerns please ask before treatment begins. Please Initial _____.

Print name: _____

Signature: _____

Date: _____

HIPAA Privacy Practices Acknowledgement Form

Due to new HIPAA compliance statutes, we as a healthcare provider are required to provide you with a Notice of Privacy Practices that describes your rights as a patient and must document that every patient or client has read and received it. The form is found on our website and is available at our center for you to read and take home with you. By Signing below, I acknowledge the receipt of the Notice of Privacy Practices at Union Center For Healing Integral, PLLC.

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Printed Name_____Signature _____ Date_____
(Of patient, parent or representative)

Communication Consent

We are required (UCFH and the individual provider) to have your consent to communicate via Email, Fullslate (online scheduling), Acusimple, and Text. At this time the emails, text and Fullslate are not encrypted. We are able to communicate with you by each of these forms but need your consent to do so. If you have sensitive health care information you wish to share through email, contact your provider first so we can send an encrypted message.

I consent to communicate by email, text, and Fullslate: Yes _____ No _____

Late Cancellation & Missed Appointment Agreement

Please provide 24 hours advance notice of any changes or cancellations unless due to illness or injury. Our fee for appointments that are missed/rescheduled/cancelled with less than 24 hours notice is $70 for Mercier Therapy.

Signature: _____ Date:_____

Map and Parking

Union Center For Healing
2100 East Union Street
Seattle, Washington 98122

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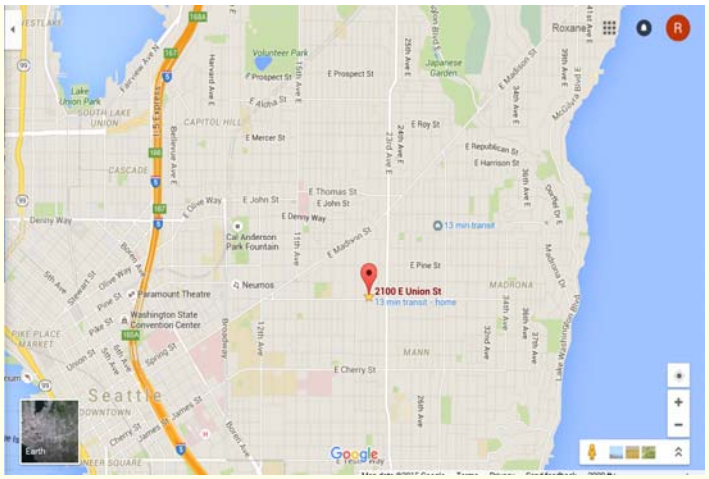

For written directions and tips on getting here and avoiding downtown, please see our website:

http://unioncenterforhealing.com/yourfirstvisit/directions.html

We have plenty of on street parking right in front!

206.329.2060 • 2100 E Union Street Seattle, WA 98122 • info@unioncenterforhealing.com • UnionCenterForHealing.com