

Treatment(s) you have received for this Condition 1) _____

2) _____ 3) _____

SYMPTOMS – NOTE: For each symptom you currently have, rate its severity from 1-5 (5 being the worst).

Leave blank if Not Applicable.

LIVER / GALLBLADDER

- _____ Irritability / Anger
- _____ Depression / Stress
- _____ Headaches / Migraines
- _____ Visual Problems
- _____ Red / Dry / Itchy Eyes
- _____ Gall Stones
- _____ Dizziness
- _____ Blurred Vision
- _____ Feeling of Lump in Throat
- _____ Clenching of Teeth at Night
- _____ Muscle Cramping / Twitching
- _____ Tension
- _____ Joints/Neck/Shoulder Pain/Tight
- _____ Poor Circulation
- _____ Soft / Brittle Nails
- _____ Emotional Eater
- _____ Bad Taste

- _____ Poor Memory
- _____ Loss of Hair
- _____ Hearing Problems
- _____ Cavities
- _____ Fear
- _____ Hot Flash/ Night Sweating
- _____ Do you crave: Salty

Heart / Small Intestine

- _____ Heart Palpitations
- _____ Chest Pain
- _____ Insomnia / Sleep Problems
- _____ Easily Startled
- _____ Restlessness / Agitation
- _____ Vivid Dreams
- _____ Lack of Joy in Life
- _____ Do you crave: Bitter

- _____ Low Resistance to Colds or Flu
- _____ Sneezing
- _____ Mild Fever Comes & goes
- _____ Smokes Cigarettes
- _____ Emphysema
- _____ Bronchitis
- _____ Black / Blood in Stools
- _____ Constipation
- _____ IBS
- _____ Colitis/ Spastic Colon
- _____ Diarrhea
- _____ Do you Crave : Pungent

SPLEEN / STOMACH

- _____ Heaviness Anywhere in the Body
- _____ Fatigue on a Scale of 1(**low**) –10 (**high**)
- _____ Hard to get up in the Morning
- _____ Muscles Feel Tired Often
- _____ Edema (swelling) hands feet
- _____ Easily Bruising & Bleeding
- _____ Bad Breath
- _____ Nausea/ Vomiting
- _____ Difficulty Digesting Fatty Foods
- _____ Nausea/ Vomiting
- _____ Gas / Belching
- _____ Hemorrhoids
- _____ Constipation
- _____ Diarrhea
- _____ Abdominal Pain
- _____ Indigestion / Heartburn
- _____ Over - Thinking
- _____ Tendency to Gain Weight
- _____ Brain Foggy
- _____ Do you Crave: Sweet

- _____ Bad Breath
- _____ Do you Crave: Sour

LUNG / LARGE INTESTINE

- _____ Bloody Cough
- _____ Dry Cough
- _____ Cough with Sputum
- _____ Nasal Discharge / Circle Color - White Yellow Green
- _____ Post Nasal Drip / Circle Color: White Yellow Green
- _____ Sinus Infection/ Congestion
- _____ Itchy, Red, or Painful Throat
- _____ Dry Mouth/ Throat/ Nose
- _____ Skin Rashes / Hives
- _____ Snoring
- _____ Grief / Sadness
- _____ Shortness of Breath
- _____ Allergies / Asthma

KIDNEY/ URINARY BLADDER

- _____ Urinary Problems
- _____ Bladder Infection
- _____ Dropped Bladder
- _____ Incontinence
- _____ Lack of Bladder Control
- _____ Weakness/ Pain in Lower Back
- _____ Decrease Bone Density
- _____ Feel Cold Easily
- _____ Cold Hands
- _____ Cold Feet
- _____ Low Sex Drive / Libido
- _____ Excess Sexual Desire

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose sprays, and topical creams. NOTE: If need more space, use page 5.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better _____

Have you had acupuncture before? _____

If yes, who and where? _____

Any concerns or fears about the needles? _____ If yes, what? _____

What are your goals of your acupuncture visits?
 1. _____
 2. _____
 3. _____

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "C" under the appropriate person's column. "P" should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the space below.

	You	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
Age							
AIDS / HIV							
Alcohol							
Anxiety							
Anorexia / Bulimia							
Arthritis							
Asthma / Hay Fever / Allergy							
Back Trouble							
Bursitis							
Cancer							
Constipation							
Depression							
Diabetes							
Digestive Trouble							
Headaches							
Heart Trouble							
Hepatitis							
High Blood Pressure							
Immune Disorder							
Insomnia							
Kidney Trouble							
Liver Trouble							
Migraine							
Neck Pain							
Thyroid Disorder							
Tobacco							
Weight Problem							
Other Emotional Problems: _____							
Other: _____							

If any of the above family members are deceased, please list their age at death and cause.

MUSCULOSKELETAL

Muscle Cramps – Where?

Muscle Pain / Rheumatism – Where?

Arthritis – Where?

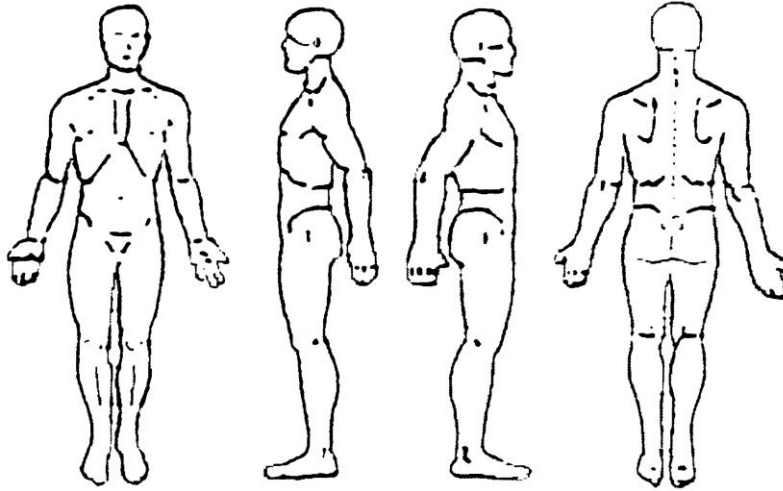
Joint Swelling – Where?

Tendonitis – Where?

Bursitis – Where?

What Makes this Better? :

Please mark problem areas on diagram:



Location of Pain	
Is the Pain	<input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Fixed <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Other: _____
On a Scale of 1 (Low) – 10 (unbearable):	
Is the Pain Better With:	<input type="checkbox"/> Rest <input type="checkbox"/> Activity <input type="checkbox"/> Ice <input type="checkbox"/> Heat <input type="checkbox"/> Other: _____ <input type="checkbox"/> Massage <input type="checkbox"/> Chiropractic

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For Men and Women
Diet Information

Please describe your appetite:

Strong Normal Poor

Do you hunger quickly? Yes No

Please describe your diet (low fat, low-carb, vegetarian, etc.)

Please list what you ate yesterday

Breakfast : _____

Lunch : _____

Dinner : _____

Snacks : _____

How much water do you drink per day? _____

Other fluids _____

Please describe your thirst

Strong Normal Poor

If you eat any of the following , please check and list how much per week

Candy _____

Cookies/ Baked Goods _____

Chocolate _____

White flour bread _____

Soda – Regular/ Diet _____

Milk _____

Cheese _____

Alcohol _____

Fast Food _____

Protein _____

Dark Green Vegetables _____

Fruit _____

Other _____

Women Only

Hysterectomy – Ovaries Removed? Yes No
Could You be Pregnant Now? Yes No

Number Of: ___ Pregnancies ___ Miscarriages
___ Births ___ Abortions

Post-menopausal Bleeding Yes No

When did your last period start? _____

Number of days for menstrual cycle? _____

Number of days bleeding lasts? _____

Describe Menstrual Flow:

Heavy Moderate Light None

Color of Menstrual Flow:

Dark Bright Red Slightly Reddish

Birth Control:

None IUD Birth Control Pills
 Spermicides Barriers

Do You Suffer From:

- Cramping (*Mark as appropriate*)
 - Cramping in Low Back In Groin Area
 - Severe Moderate
 - Mild Before Period
 - During Period Do you feel Ovulation
 - Do you us pain Medication? After Period
 - What Kind of Medication?:
- Clotting (*Mark as appropriate*)
 - Bright in Color Brown / Grainy
 - Stringy Dark in Color
 - Size of Clots : Nickel / Dime / Larger
- Bleeding Between Periods Infertility
- Pelvic Inflamm. Disease Ovarian Cysts
- STD's Hot Flashes
- Endometriosis Breast Cysts
- Mastitis
- Yeast Infection / Vaginitis / Other Discharge
- Premenstrual Syndrome (*Mark as appropriate*)
 - Fluid Retention Cravings
 - Fluctuating Emotions Irritability
 - Tenderness in Breasts Depression
 - Fatigue Loose Stool
 - Tender / Weepy

Men Only

- Impotence Weak Erection
- Discharge from Penis Prostate Problems
- Testicular Pain or Lump Infertility
- Premature Ejaculation Low Sex Drive
- STD's

Men and Women

Supplements

Name	Purpose	How Long

Notes / Anything Else

Thank you for completing this form. Your time is greatly appreciated and we value this opportunity to serve you!

Male Fertility Form

Date ____/____/____	Date of Birth ____/____/____	Age	Body Type	Height:	Weight:	Complexion:	Occupation
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Name of your doctor/ Fertility Specialist: RMFC / CCRM / FCC / Conceptions / CU
 Other OBGYN doctor _____ Start Date: _____ Month/ Year
 Western Diagnosis _____

1. Results for Sperm Analysis:

Date	Count	Morphology	Motility	Volume

2. Do we have a copy of your Semen Analysis? Y / N

3. Other Procedures/ Date:

Varicocele	Vasectomy	Vasectomy Reversal	SDFA / SCSA	Others

4. Do you take any of these Supplements and/or Vitamins?

# of Months on Vitamins	Male Vitamins	Mega Man	Fish Oil	L - Carnatine	L - Arganine	Antioxidants	EWA Complete List

Other: _____

5. Couples ART(Assisted Reproductive Technique) Plans:

IUI	Clomid	IVF	PGD	TESA	Other

6. Have you fathered children Y / N If so, how many _____

7. Male Health

Infection	Chlamydia,	Erectile Dysfunction	Ejaculation Problems	Retrograde Ejaculation	Prostate
	Y / N	Y / N	Y / N	Y / N	Y / N

8. Male Health Continued

Antisperm Antibodies	Sperm Chromatid / DNA Integrity	High Cholesterol	Diabetes (fasting, glucose)	Others
Y / N	Y / N	Y / N	Y / N	

9. Is your Spouse currently being treated by us? Y / N

10. Spouse's Name _____

11. Western Diagnosis of Spouse _____