



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

**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

**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

**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 from 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
<b>Age</b>							
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?

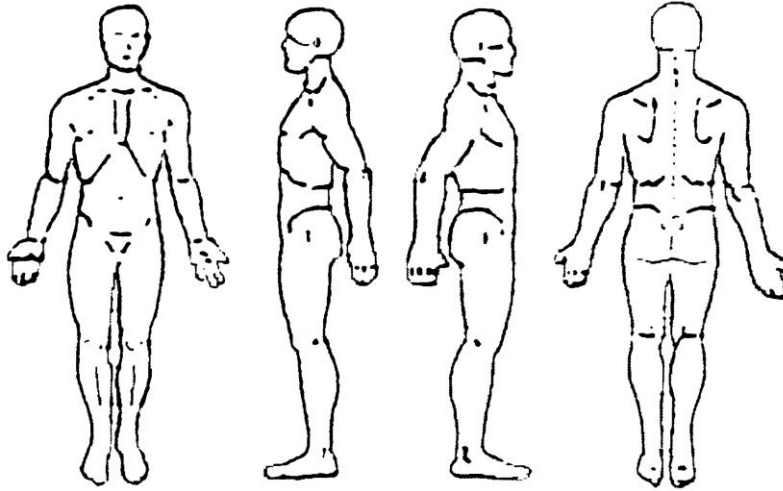
Joint Swelling – Where?

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.)

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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 \_\_\_\_\_



## Female Fertility Form

Date ____/____/____	Age	Body Type	Height:	Weight:	Complexion:	Occupation:
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LMP: \_\_\_\_\_ Cycle Duration \_\_\_\_\_  
 Are you being treated by: \_\_\_\_\_

RE & I Clinic / Fertility Specialist: RMFC / CCRM / FCC / Conceptions / CU  
 Other OBGYN doctor \_\_\_\_\_ Start Date: \_\_\_\_\_ Month/ Year

Western Diagnosis \_\_\_\_\_

### 1. Fertility treatments (including cancelled cycles):

Date	Natural, IUI IVF, Other	Medication Used	# of Mature Eggs / Follicles	Pregnancy Yes/No	If Miscarried , Indicate at which Week	Other Comments and Locations

### 2. Your Diagnostics / Date

Elevated FSH	Uterine Fibroids / Polyps	Endometriosis / Adhesions	PCOS	POF	Low Progesterone Level	PID	STD's	Herpes

Others:

### 3. If you have PCOS, are you taking:

Glucophage	Fortamet	How long?	Are you taking extra B-Complex Vitamins?

### 4. Female Health:

PID	Chlamydia	STD's	Herpes	Antisperm Antibodies	Others

### 5. Procedures performed / Dates

Laparoscopy	HSG-Hysterosalpingogram	Others:

### 6. Lab Results/ Dates

FSH Level Day 3	HCG	Prolactin	TSH	T3:	T4:	Free T4:	OAR	Others

### 7. Lab Results on File      Y / N

### 8. Supplements and/or Vitamins?

Date	Prenatal	Fish Oil	Greens Plus	Antioxidants	Royal Jelly/ Propolis	Additional Folic Acid	Others

**9. Planned ART / Date:**

IUI w/ Injectables	IUI w/ Oral Meds	Clomid	IVF	PGD	Other

**10. Fertility History / Dates**

Pregnancies	Children	Miscarriages	Abortions	Ectopics	D&C	Abnormal Pap Smear	Others

**11. Other:**

Age at which menses began? _____ Oral Contraceptive Pill? _____ How long? _____ List name of birth control _____ How long have you tried to conceive? _____ Clomid challenge test? _____ Date: _____ Day 3 _____ at Day 10 _____ at _____ (month/year) Recurrent yeast infections? _____ How often? _____	Natural Ovulation ..... Y / N Which day of your cycle are you on today ____ to ____ Typically, how many days are there from one period to the next ____ to ____ days? Today is which day of your cycle? _____ Current month treatment plan _____ (Natural, IUI, IVF, Any Tests, etc.)
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**9. PMS**

	10 Days Before	1 Week Before	2-3 Days Before
Breast Tenderness			
Depression			
Fatigue			
Low Back Pain			
Face Break Out			
Other			

**10. Menstrual History**

Symptoms (please check each day)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6-7
Do you have Back Pain?						
Cramps (Light, Medium, Severe)						
Color (Light Red / Red / Dark Red / Brown)						
How Heavy is Flow (Light, Normal, Heavy)						
Is there Clotting?						
Is there Spotting?						

**11. Is partner currently being treated by us? Y / N**

**12. Partner's Name** \_\_\_\_\_

**13. Western Diagnosis of the partner:** \_\_\_\_\_

**14. Do we have copies of labs / sperm analysis Y / N**

**15. Results for Sperm Analysis:**

Date	Count	Morphology	Motility	Volume

**16. Male Reproductive History/ Date:**

Varicocele	Vasectomy	Vasectomy Reversal	SCSA / DNA	Anti- Sperm Antibodies	Others

**17. Following Fertility :**

Basal Body Temperature Chart	Y / N	Avoid Ice cold Foods.....	Y / N
Timed Sex .....	Y / N	Avoid Tampons.....	Y / N
Stress Reduction .....	Y / N	Femoral Massage .....	Y / N
Diet Principals :		Visualization.....	Y / N
<input type="checkbox"/> Yin		Meditation .....	Y / N
<input type="checkbox"/> Yang		Yoga .....	Y / N
<input type="checkbox"/> Blood		Qi Gong.....	Y / N
<input type="checkbox"/> Qi		Deep Breathing.....	Y / N
<u>Ovulation</u>		Journaling.....	Y / N
(LH) Luteinizing Hormone Sticks	Y / N	Foot Soaks.....	Y / N
(OPK) Ovulation Predictor Kit	Y / N	Feminine Hygiene.....	Y / N
Relationship / Sex .....	Y / N	Detox.....	Y / N
		Type of Detox	
		Feng Shui.....	Y / N