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Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date	First Name	Last Name	Middle Initial
_____ / _____ / _____			

Gender **M F**	Date of Birth _____ / _____ / _____	Age	Eye Color:	Height:	Weight:

Street Address	City	State	Zip

Phone (Daytime) – **Home Work Mobile** *Circle One*	Phone (Nighttime) **# – Home Work Mobile** *Circle One*
( )	( )
Alternate Phone **# – Home Work Mobile** *Circle One*	Place of Employment / Occupation
Name & Phone Numbers of Partner: Primary ( ) Alternate ( )	Name & Phone Numbers of Emergency Contact: Primary ( ) Alternate ( )
E-Mail:	

How did you hear about us? *Please circle one and write the name*

Current Patient: _____ Doctor: _____Advertisement: _____ Friend: _____Insurance: _____
Other:_____

Have you received a Diagnosis for your condition(s)? Y / N If so what: By Whom:	Have you had Acupuncture before? Y / N Did you have a positive ☐ Experience ☐ Out come

	Severe	Moderate	Slight	Major Complaint(s), in order of **importance** to you:
1.	☐	☐	☐	
2.	☐	☐	☐	
3.	☐	☐	☐	
4.	☐	☐	☐	
5.	☐	☐	☐	

When/how did this condition occur? Give dates if possible. 1) _____

2) _____ 3) _____

How do these conditions impair your daily activities? 1) _____

2) _____ 3) _____

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Treatment(s) you have received for this condition: 1) _____

2) _____ 3) _____

What treatments helped the most? 1) _____

2) _____ 3) _____

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.		**ALLERGIES** Medications, Seasonal, Environmental, Food.	**OCCUPATIONAL CONCERNS** Check (√) if your work exposes you to the following:	**DIET & EXERCISE** Check (√) all that apply.
Year	**Surgery/ Hospitalization/ Accidents/ Trauma (Physical & Emotional)**		☐ Stress ☐ Environmental ☐ Heavy Typing ☐ Heavy Lifting ☐ Others:	☐ Regular Exercise ☐ Low-Fat ☐ Low-Carb ☐ Vegetarian
				☐ Other:
				☐ Drink Coffee: Cups/Day
			Occupation: _____	☐ Drink Soda oz/Day

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

SUPPLEMENTS

Name	Purpose	How Long	Dose	How Often	Last Dose

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

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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
_____ Bad Breath
_____ Do you Crave: Sour

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
_____ 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
_____ Do you crave: Bitter

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
_____ 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

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FEMALE FERTILITY FORMS

Date / /	First Name	Last Name	Middle Initial

Date of Birth / /	Age	Body Type	Height:	Weight:	Occupation:

LMP: _____ Cycle Duration _____

Reproductive Endocrinologist: _____ Start Date: _____ Month/ Year
Other OBGYN doctor _____ Start Date: _____ Month/ Year

Other RE & Clinic _____ 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. Diagnostics / Date

Elevated FSH	Uterine Fibroids / Polyps	Endometriosis / Adhesions	PCOS	POF	Low Progesterone Level	Antisperm Antibodies

Others:

3. If you have PCOS, are you taking:

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

4. Female Health:

PID	Chlamydia	STD's	Herpes	Other STD's

5. Procedures performed cont. / Dates

Laparoscopy	HSG-Hysterosalpingogram	Others:

6. Lab Results/ Dates

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

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7. Lab Results Available? **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? _____ OCP (Birth Control Pill) _____ How long? _____ List name of birth control _____ How long have you been trying 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 _____ to _____ Typically, how many days are there from one period to the next _____ to _____ days? Today is which day of patient's cycle? _____ Current month treatment plan _____ (Natural, IUI, IVF, Any Tests, etc.)

12. PMS

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

13**. 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?						

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

Partner's Name _____

Western Diagnosis of the partner: _____

15. Are labs / sperm analysis available? **Y / N**

16. Results for Sperm Analysis:

Date	Count	Morphology	Motility	Volume

17. Male Reproductive History/ Date:

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

18. Tracking your Fertility :

Basal Body Temperature Chart Y / N
Timed Sex …… Y / N

Ovulation

LH Sticks …… Y / N
OPK …… Y / N