

moss acupuncture

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? <i>Please circle one and write the name</i> 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 <input type="checkbox"/> Experience <input type="checkbox"/> Out come			

	Severe	Moderate	Slight	Major Complaint(s), in order of importance to you:
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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)		<input type="checkbox"/> Stress <input type="checkbox"/> Environmental <input type="checkbox"/> Heavy Typing <input type="checkbox"/> Heavy Lifting <input type="checkbox"/> Others:	<input type="checkbox"/> Regular Exercise <input type="checkbox"/> Low-Fat <input type="checkbox"/> Low-Carb <input type="checkbox"/> Vegetarian <input type="checkbox"/> Other:
				<input type="checkbox"/> Drink Coffee: Cups/Day
			Occupation: _____	<input type="checkbox"/> 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

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: _____							

**SYMPTOMS – NOTE: For each symptom you currently have, rate its severity from 1-5 (5 being the worst).
Leave blank if Not Applicable.**

<p>LIVER / GALLBLADDER</p> <p>_____ Irritability / Anger</p> <p>_____ Depression / Stress</p> <p>_____ Headaches / Migraines</p> <p>_____ Visual Problems</p> <p>_____ Red / Dry / Itchy Eyes</p> <p>_____ Gall Stones</p> <p>_____ Dizziness</p> <p>_____ Blurred Vision</p> <p>_____ Feeling of Lump in Throat</p> <p>_____ Clenching of Teeth at Night</p> <p>_____ Muscle Cramping / Twitching</p> <p>_____ Tension</p> <p>_____ Joints/Neck/Shoulder Pain/Tight</p> <p>_____ Poor Circulation</p> <p>_____ Soft / Brittle Nails</p> <p>_____ Emotional Eater</p> <p>_____ Bad Taste</p> <p>_____ Bad Breath</p> <p>_____ Do you Crave: Sour</p> <p>KIDNEY/ URINARY BLADDER</p> <p>_____ Urinary Problems</p> <p>_____ Bladder Infection</p> <p>_____ Dropped Bladder</p> <p>_____ Incontinence</p> <p>_____ Lack of Bladder Control</p> <p>_____ Weakness/ Pain in Lower Back</p> <p>_____ Decrease Bone Density</p> <p>_____ Feel Cold Easily</p> <p>_____ Cold Hands</p> <p>_____ Cold Feet</p> <p>_____ Low Sex Drive / Libido</p> <p>_____ Excess Sexual Desire</p>	<p>_____ Poor Memory</p> <p>_____ Loss of Hair</p> <p>_____ Hearing Problems</p> <p>_____ Cavities</p> <p>_____ Fear</p> <p>_____ Hot Flash/ Night Sweating</p> <p>_____ Do you crave: Salty</p> <p>Heart / Small Intestine</p> <p>_____ Heart Palpitations</p> <p>_____ Chest Pain</p> <p>_____ Insomnia / Sleep Problems</p> <p>_____ Easily Startled</p> <p>_____ Restlessness / Agitation</p> <p>_____ Vivid Dreams</p> <p>_____ Do you crave: Bitter</p> <p>LUNG / LARGE INTESTINE</p> <p>_____ Bloody Cough</p> <p>_____ Dry Cough</p> <p>_____ Cough with Sputum</p> <p>_____ Nasal Discharge / Circle Color</p> <p>_____ -</p> <p>_____ White Yellow Green</p> <p>_____ Post Nasal Drip / Circle Color:</p> <p>_____ White Yellow Green</p> <p>_____ Sinus Infection/ Congestion</p> <p>_____ Itchy, Red, or Painful Throat</p> <p>_____ Dry Mouth/ Throat/ Nose</p> <p>_____ Skin Rashes / Hives</p> <p>_____ Snoring</p> <p>_____ Grief / Sadness</p> <p>_____ Shortness of Breath</p> <p>_____ Allergies / Asthma</p>	<p>_____ Low Resistance to Colds or Flu</p> <p>_____ Sneezing</p> <p>_____ Mild Fever Comes & goes</p> <p>_____ Smokes Cigarettes</p> <p>_____ Emphysema</p> <p>_____ Bronchitis</p> <p>_____ Black / Blood in Stools</p> <p>_____ Constipation</p> <p>_____ IBS</p> <p>_____ Colitis/ Spastic Colon</p> <p>_____ Diarrhea</p> <p>_____ Do you Crave : Pungent</p> <p>SPLEEN / STOMACH</p> <p>_____ Heaviness Anywhere in the Body</p> <p>_____ Fatigue on a Scale of 1(low) –10 (high)</p> <p>_____ Hard to get up in the Morning</p> <p>_____ Muscles Feel Tired Often</p> <p>_____ Edema (swelling) <input type="checkbox"/> hands <input type="checkbox"/> feet</p> <p>_____ Easily Bruising & Bleeding</p> <p>_____ Bad Breath</p> <p>_____ Nausea/ Vomiting</p> <p>_____ Difficulty Digesting Fatty Foods</p> <p>_____ Nausea/ Vomiting</p> <p>_____ Gas / Belching</p> <p>_____ Hemorrhoids</p> <p>_____ Constipation</p> <p>_____ Diarrhea</p> <p>_____ Abdominal Pain</p> <p>_____ Indigestion / Heartburn</p> <p>_____ Over - Thinking</p> <p>_____ Tendency to Gain Weight</p> <p>_____ Brain Foggy</p> <p>_____ Do you Crave: Sweet</p>
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MALE FERTILITY FORMS

Date / /	First Name	Last Name			Middle Initial
Date of Birth / /	Age	Body Type	Height:	Weight:	Occupation:

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 you have a copy of your Semen Analysis?

Y / N

3. Other Procedures/ Date:

Varicocele	Vasectomy	Vasectomy Reversal	SCSA / ASA	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 Plans:

IUI	Clomid	IVF	PGD	TESA	Other

6. Has the patient father 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 you Spouse currently being treated by us?

Y / N

Spouse's Name _____
 Western Diagnosis of Spouse _____