Patient Information Sheet

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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	Social Security Number — —

Gender **M F**	Date of Birth _____ / _____ / _____	Age	Marital Status **Single Married Separated Divorced**

Street Address	City	State	Zip

Phone (Daytime) – **Home Work Mobile** *Circle One* ( )	Alternate Phone # – **Home Work Mobile** *Circle One* ( )
Place of Employment --- Occupation -------------------------	Phone Numbers of Emergency Contact Primary ( ) Alternate ( )

Circle Insurance Coverage (Please circle one)

None Workers' Comp Auto Injury Health Insurance Company_________________________

Would you like to receive a monthly e-mail acupuncture newsletter? **Y N**

E-Mail:

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

Current Patient: __________ Doctor: __________Advertisement: __________ Friend: ________Insurance: ___________ Other: ____________

Chief complaint: ____

How long? ________________________ How often: ____________________________

What caused this (accident, lifestyle, drug, etc.)? ______________________________

Describe the worst it can be: ____

What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? ___________________

Get temporary relief? _______ Fixes problem? _______ Causes side effects? _______

How does this affect your life? ______________________________________

Affect your family? ________________________ Affect your sleep? ________________

Affect your work? _________________________ Affect your hobbies? ________________

What is your goal/plan if the problem continues 5/10/20 years? _________________________

Complaint #2: ____

How long? ________________________ How often: ____________________________

What caused this (accident, lifestyle, drug, etc.)? ______________________________

Describe the worst it can be: ____

What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? ___________________

Get temporary relief? _______ Fixes problem? _______ Causes side effects? _______

How does this affect your life? ______________________________________

Affect your family? ________________________ Affect your sleep? ________________

Affect your work? _________________________ Affect your hobbies? ________________

What is your goal/plan if the problem continues 5/10/20 years? _________________________

Other Complaints:

3) ______________________________ 4) ______________________________

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, where/who ________________________
Any concerns or fears about the needles? ______
If yes, what? ____________________________
What are your goals of your acupuncture visits?
1. __________________________________
2. __________________________________
3. __________________________________

	MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.	ALLERGIES Medications, Seasonal, Environmental, Food.

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops and nose sprays. NOTE: If need more space, use page 4.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

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

KIDNEY / URINARY BLADDER

_____ Urinary Problems
_____ Bladder Infection
_____ Lack of Bladder Control
_____ Weakness / Pain in Lower Back
_____ Decrease Bone Density
_____ Feel Cold Easily
_____ Low Sex Drive
_____ Excess Sexual Desire
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities
_____ Craving / Avoiding Salty Foods
_____ Fear
_____ Hot Flush / Night Sweating

HEART / SMALL INTESTINES

_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life

LUNG / LARGE INTESTINE

_____ Dry Cough
_____ Cough with Sputum
_____ Nasal Discharge
_____ Post-Nasal Drip
_____ 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
_____ Smoke Cigarettes

SPLEEN / STOMACH

_____ Heaviness Anywhere in Body
_____ Fatigue / Worse After Eating
_____ Hard to Get Up in the Morning
_____ Edema (Swelling)
_____ Muscles Feel Tired Often
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____ Decreased / Increased Appetite
_____ Crave Sweets
_____ Hypoglycemia
_____ Difficulty Digesting Oily Foods
_____ Nausea / Vomiting
_____ Gas / Belching
_____ Insulin Sensitivity
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over-Thinking
_____ Tendency to Gain Weight
_____ Brain Foggy

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 reverse side of this form.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
AIDS / HIV											
Alcohol											
Anxiety											
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.

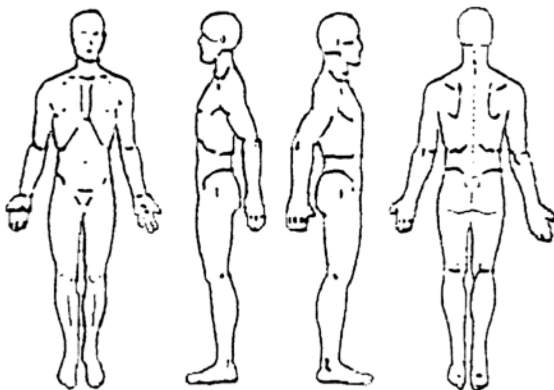
____

MUSCULOSKELETAL

☐ Muscle Cramps – Where? ☐ Muscle Pain / Rheumatism – Where? ☐ Arthritis – Where?

☐ Joint Swelling – Where? ☐ Tendonitis – Where? ☐ Bursitis – Where?

Please mark problem areas on diagram:



Describe Pain and Location

☐ Sharp ☐ Burning ☐ Aching

☐ Fixed ☐ Other:_____________________

☐ Sharp ☐ Burning ☐ Aching

☐ Fixed ☐ Other:_____________________

☐ Sharp ☐ Burning ☐ Aching

☐ Fixed ☐ 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 end? ____________

Number of days for monthly 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)*
- ☐ Severe ☐ Moderate
- ☐ Mild ☐ Before Period
- ☐ During Period ☐ After Period

☐ Clotting *(Mark as appropriate)*
- ☐ Bright in Color ☐ Dark in Color

☐ Bleeding Between Periods ☐ Infertility
☐ Pelvic Inflam. Disease ☐ Ovarian Cysts
☐ Endometriosis ☐ Hot Flashes
☐ Mastitis ☐ Breast Cysts
☐ Yeast Infection / Vaginitis / Other Discharge

☐ Premenstrual Syndrome *(Mark as appropriate)*
- ☐ Fluid Retention ☐ Cravings
- ☐ Fluctuating Emotions ☐ Irritability
- ☐ Tenderness in Breasts ☐ Depression
- ☐ Fatigue

Men Only

☐ Impotence ☐ Weak Erection
☐ Discharge from Penis ☐ Prostate Problems
☐ Testicular Pain or Lump ☐ Infertility
☐ Premature Ejaculation ☐ Low Sex Drive

Men and Women

Supplements

Name	Purpose	How Long

Diet

What kinds (circle)	How much per day/week
Sugar: Candy	
Cookies / Baked goods	
Regular Soda / Diet Soda	
Chocolate	
Diary: Milk	
Cheese	
Yogurt	
Ice-cream	
White Flour: Bread	
Pasta	
Coffee	
Alcohol	
Protein 50g per day?	
Eggs	
Dark green/vegetables	
Fruits	
Eat Breakfast?	
Eat fast food / on the run?	

Additional Notes

____
____
____
____
____
____

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

AcuForConception.com # Women's Fertility History **CONFIDENTIAL**

Name of your doctor / fertility specialist: Conceptions / CCRM / CRE / Kaiser / University Hospital / Other OBGYN doctor: _________________________________ Name of person who told you about us? _________________________________
Start date: _______________ month/year Current Month Treatment Plan _____________________ (IVF / IUI / Natural / Tests / Etc.)

1. Please list below all pregnancies and 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. Do you have any of these diagnoses?

	High FSH / AMH	Uterine Fibroids / Polyps	Endometriosis / Adhesions	PCOS	POF	Low Progesterone Level
Date						

Others:

3. Have you ever have any of these infertility tests or procedures?

	Laparoscope	HSG-Hysterosalpingography	Others:
Date			

4. Do you have any of these? If yes please list how many.

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

5. Other:

Age at which menses began? ____________
Do you take birth control? ____________ If yes, how long? ____________
List name of birth control ____
Has your husband been checked out for fertility problems? ____
How long have you been trying to get pregnant? _____________
At Day 3______ at Day 10______ at _____________(month/year)
Do you get recurrent yeast infections? _________ How often? ___________

Do you have to do a Clomid challenge test? _______
Do you ovulate on your own? ________
How can you tell you ovulate? _______________
Which day of your cycle ______ to ______
Have you done BBT testing? _______
Typically, how many days are there from one period to the next _____ to _____ days?
Today is which day of your cycle? ________

6. List any PMS symptoms before period:

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

7. How is your period each day? Please check each day:

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