Harmony and Health Acupuncture
4020 N 20th St #212 Phoenix, AZ 85016 602-955-5444

Confidential Patient Information Form - Fertility

PERSONAL INFORMATION

First Name_____ Last Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Best Phone to Reach You_____ Text Message Appointments Reminders ☐Yes ☐ No

Email Address_____ Please check if you are willing for us to contact you by email ☐Yes ☐ No

Date of Birth_____ Marital Status_____ Number of Children_____ Age(s) of Children_____

Occupation _____ Employer_____

Highest level of education completed: ☐High School ☐Bachelors ☐Masters ☐Doctorate ☐Professional ☐Other_____

In emergency notify:_____ Emergency Phone Number:_____

Primary Care Physician:_____ Last Seen:_____

Have you had acupuncture before? ☐No ☐Yes Name of Acupuncturist:_____

Major Complaint(s) in order of significance to you:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are you being treated by an OB/Gyn, or Fertility Specialist ☐No ☐Yes If yes, who_____

If treated by a Medical Doctor is their a diagnosis? ☐ No ☐ Yes (Diagnosis) _____

Do you have any known or suspected allergies ☐No ☐Yes (List) _____

Height _____ Weight _____ Age _____ Gender: ☐Male ☐Female ☐_____

Please List the Medications and Supplements you are currently taking:

Drug/Supplement	Reason for Taking	For how Long	Dose	Frequency

Are you currently taking Coumadin/warfarin or heparin? ☐ No☐ Yes

MEDICAL INFORMATION

Please list any serious diseases, injuries, surgeries or hospitalizations you have had and the year they occurred:

_____

_____

_____

Please check any that apply to your medical history:

□ADD/ADHD	□Eating Disorder	□Lyme's Disease	□Seizures/Epilepsy
□Alcoholism	□Fibromyalgia	□Mental Illness	□Sinus Infections
□Allergies	□Glaucoma	□Migraines	□Skin Disease
□Arthritis	□Heart Disease	□Multiple Sclerosis	□Stroke
□Bipolar Disease	□Hepatitis/Liver disease	□Osteoporosis	□Substance Abuse
□Birth Trauma	□High Blood Pressure	□Pacemaker	□Thyroid Disease
□Bleeding Disorder	□HIV/AIDS	□Polio	□Tuberculosis
□Blood Disease	□Immune Disorder	□Prostate Problems	□Ulcer
□Cancer or Tumor	□Joint Replacement	□PTSD	□Vein Condition
□Depression	□Kidney Disorder	□Rheumatic Fever	□Venereal Disease/STD
□Diabetes	□Low Blood Pressure	□Scoliosis	□Other
□Emphysema	□Lupus	□Scarlet Fever	

LIFESTYLE INFORMATION

Please include daily amount used within the past 2 months:

Tobacco: □No □Yes Amount:_____ Alcohol: □No □Yes Amount: _____ Coffee □No □Yes Amount:_____
Recreational Drugs: □No □Yes Amount:_____ Daily water intake:_____ Daily soda intake: _____

Are you a vegetarian or vegan? □No □Yes Hours of sleep/night:_____

How would you rate the following areas of your health in the past month?

Energy: □Great □Good □Fair □Poor Comments:_____
Digestion: □Great □Good □Fair □Poor Comments:_____
Urination: □Great □Good □Fair □Poor Comments:_____
Bowel movements □Great □Good □Fair □Poor Comments:_____
Sleep: □Great □Good □Fair □Poor Comments:_____
Appetite: □Great □Good □Fair □Poor Comments:_____

Physical exercise you do regularly:_____ Hours you spend at work per week: _____

How do you feel about the following areas of your life in the past month?

Significant Other: □Great □Good □Fair □Poor □N/A Comments:_____

Family: □Great □Good □Fair □Poor □N/A Comments:_____

Diet: □Great □Good □Fair □Poor □N/A Comments:_____

Sex Life: □Great □Good □Fair □Poor □N/A Comments:_____

Self: □Great □Good □Fair □Poor □N/A Comments:_____

Work: □Great □Good □Fair □Poor □N/A Comments:_____

Exercise: □Great □Good □Fair □Poor □N/A Comments:_____

How would your rate your current stress level? □Extreme □Very High □High □Moderate □Low

HEALTH INVENTORY

Please check all that currently pertain to you

Overall Temperature
- ☐ Cold Hands
- ☐ Cold feet
- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Body feels hot often
- ☐ Body feels cold often
- ☐ Afternoon flushes
- ☐ Night Sweats
- ☐ Heat in the hands, feet and chest
- ☐ Hot flashes any time of day
- ☐ Thirsty a lot
- ☐ Perspire easily
- ☐ Lack of perspiration

Overall Energy (Lu, Ki)
- ☐ Shortness of breath
- ☐ Difficulty keeping eyes open during day
- ☐ General weakness
- ☐ Easily catch colds
- ☐ Low energy
- ☐ Feel worse after exercise

Overall function of the blood (Lu, Ki Ht)
- ☐ Dizziness
- ☐ Floating spots in eyes
- ☐ Poor memory

Heart Function
- ☐ Palpitations
- ☐ Anxiety
- ☐ Sores on tip of tongue
- ☐ Restlessness
- ☐ Mental confusion
- ☐ Chest pain
- ☐ Frequent or vivid dreams
- ☐ Easily startled
- ☐ Wake un-refreshed

Stomach Function
- ☐ Burning sensation after eating
- ☐ Large appetite
- ☐ Bad breath
- ☐ Mouth (canker sores)
- ☐ Bleeding swollen or painful gums
- ☐ Heartburn
- ☐ Acid regurgitation
- ☐ Ulcer
- ☐ Belching
- ☐ Hiccoughs
- ☐ Stomach pain
- ☐ Vomiting

Eyes
- ☐ Itchy
- ☐ Bloodshot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry vision
- ☐ Decreased night vision

Lung Function
- ☐ Nasal discharge Color:_____
- ☐ Post nasal drip
- ☐ Sneezing
- ☐ Cough
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Dry mouth
- ☐ Dry throat
- ☐ Dry nose
- ☐ Dry skin
- ☐ Skin rashes, hives
- ☐ Allergies To:_____
- ☐ Alternating chills and fever
- ☐ Overall achy feeling
- ☐ Stiff neck (recent)
- ☐ Stiff shoulders (recent)
- ☐ Sore Throat
- ☐ Difficulty breathing
- ☐ Sadness, Grief
- ☐ Melancholy

Spleen (Digestive) Function
- ☐ Low appetite
- ☐ Abrupt weight gain
- ☐ Abrupt weight loss
- ☐ Abdominal bloating
- ☐ Abdominal gas
- ☐ Gurgling noise in stomach
- ☐ Fatigue after eating
- ☐ Prolapsed organs, bladder, rectum, uterus
- ☐ Easy bruising
- ☐ Hemorrhoids
- ☐ Pensive
- ☐ Over-thinking
- ☐ Worry

Intestine Function Sp, St, LI, SI
- ☐ Loose stool
- ☐ Constipated
- ☐ Frequent stool
- ☐ Incomplete feeling
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Mucus in stool
- ☐ Undigested food in stool

Dampness trapped in body
- ☐ General sensation of heaviness in the body
- ☐ Mental heaviness
- ☐ Mental sluggishness
- ☐ Mental fogginess
- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Swollen joints
- ☐ Chest congestion
- ☐ Nausea
- ☐ Snoring

Libido (Sex Drive)
- ☐ Normal ☐ High ☐ Low

Liver/Gallbladder Function
- ☐ Alternating diarrhea & constipation
- ☐ Chest pain
- ☐ Tight sensation in chest
- ☐ Pain below ribcage
- ☐ Bitter taste in mouth
- ☐ Anger easily
- ☐ Frustration
- ☐ Depression
- ☐ Irritability
- ☐ Headache at temples or top of head
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Tendonitis
- ☐ Muscle spasms
- ☐ Muscle twitching
- ☐ Muscle cramping
- ☐ Seizures
- ☐ Convulsions
- ☐ Feeling of lump in the throat
- ☐ Neck tension
- ☐ Neck limited range of motion
- ☐ Shoulder tension
- ☐ Shoulder limited range of motion
- ☐ Hip pain
- ☐ High pitched ringing in ears
- ☐ Gall stones
- ☐ Clenching of teeth at night
- ☐ Poor circulation
- ☐ Soft brittle nails

Kidney, Bladder Function
- ☐ Frequent cavities
- ☐ Easily broken bones
- ☐ Sore knees
- ☐ Weak knees
- ☐ Cold sensation in the knees
- ☐ Low back pain
- ☐ Memory problems
- ☐ Excessive hair loss
- ☐ Low pitched ringing in the ears
- ☐ Kidney stones
- ☐ Bladder infections
- ☐ Wake at night 2 times or more to pee
- ☐ Lack of bladder control
- ☐ Fear

Urination
- ☐ Normal color, clear
- ☐ Dark yellow
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong odor
- ☐ Burning, painful
- ☐ Difficult
- ☐ Urgent
- ☐ Frequent

Women Only:
How long have you been trying to concieve?_____ Method(s) of birth control used, time used and dates stopped:_____
_____

Date of last menses: _____ Typical length of cycle (from 1st day of flow to the day before next flow):_____

Typical length of flow (number of days bleeding):_____

During your flow (circle all that apply): Light red blood, Bright red blood, Dark red blood, Purple blood, Brown blood, Black Blood, normal quantity, heavy quantity, light quantity, clots (clot size, circle most appropriate: quarter, dime, pea), dull pain/cramps___, sharp pain/cramps # of days ___, nausea

Do you experience any of the following **pre-menstrual symptoms**?
□Nausea □Vomiting □Water retention □Breast swelling □Breast tenderness
□Food cravings □Headaches □Migraines □Depression □Irritability
□Anxiety □Vaginal discharge □Bleeding or spotting between periods □Pimples
□ Cramps, number of days, strength: _____ □Other:_____

What methods have you used to conceive: □Timed intercourse □App, □Ovulation Prediction Kits OPK
Number of pregnancies:_____ Births: _____ Abortions:_____ Miscarriages:_____ D&C's_____

Age at which menses began:_____

Do you experience any of the following: (mark all that apply) □Chronic Vaginal Discharge □ Regular Yeast Infections □Excessively oily skin □ Excessive facial hair □ Excessive loss of hair

Have you had fertility treatments? Yes No If yes When?_____ By Whom? _____ What Types _____

Have you taken medication to help you ovulate? Yes No When, How Long?

Have you had any of the following tests related to fertility?
□HSG (evaluation of fallopian tubes)
□Hormone laboratory Tests
□Thyroid Tests
□Semen Analysis

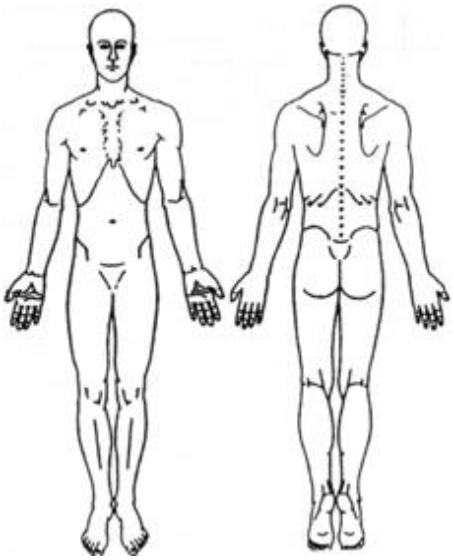
Have you ever been diagnosed with any of the following: (circle all that apply) uterine fibroids, endometriosis, pelvic abnormalities, PCOS

If you have a male partner, how committed is he to conceiving?
□Very committed (willing to make lifestyle changes and/or have treatment if necessary)
□Somewhat committed (open to making lifestyle changes and/or having treatment)
□Uncommitted (not willing to make lifestyle changes or receive treatment)

Do you plan to use donor sperm or egg? Yes No

Men Only: **Mark all that apply**
□Swollen testes □Premature ejaculation □Semen Analysis, fertility workup completed
□Testicular pain □Difficult urinary flow
□Impotence □Feeling of coldness or numbness in external genitalia

PAIN



Please answer the following questions if you have pain.
Indicate on the diagram on the left the areas of pain.

Quality of Pain: □Dull □ Sharp □ Stabbing □ Sore □ Cramping □ Burning
□ Constant □ Fixed □ Moves about

What helps the pain? □ Ice □ Heat □ Rest □ Movement □ Pressure □ Moisture
□ Massage □ Nothing □ Other _____

What aggravates the pain? □ Ice □ Heat □ Rest □ Movement □ Pressure
□ Moisture □ Massage □ Nothing □ Other _____

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Harmony and Health Acupuncture and Herbal Medicine **24 hours prior to any cancellations or changes to my appointment times** and that if I do not I may be charged for the appointment.

Signed:_____ Date:_____

Parent/Guardian (if applicable): _____