Confidential Patient Information Today's Date:

First Name:	Birthday:	Sex at Birth: M F O
Last Name:	Age:	Current Gender Identity:

Issue & Brief History: (please list in order of importance)	How long you have noticed?	Being Treated? And if so, by whom?
1.		❏ Yes ❏ No
2.		❏ Yes ❏ No
3.		❏ Yes ❏ No
4.		❏ Yes ❏ No

What do YOU think is causing your problem?	What are you hoping we will be able to do for you?
How would you know that your treatment is complete?	Have you had Acupuncture before? Yes No
	Chinese Herbal Medicine? Yes No

Review of Symptoms | Pain Presentation

Using the diagram below, mark areas of your body where you currently feel pain or other abnormal sensation. Also indicate where your pain travels (if appropriate). You can also write notes next to your markings if a description would be helpful. Then, please answer the questions to the left by circling the number that best represents your pain, where 1 is no pain and 10 is the worst pain you can imagine.

Scars: Use the diagram to the right to draw any scars (major or minor) that you have.

Rate your pain by circling the one number that best describes your pain at its **WORST in the past 24 hours.**

1 2 3 4 5 6 7 8 9 10

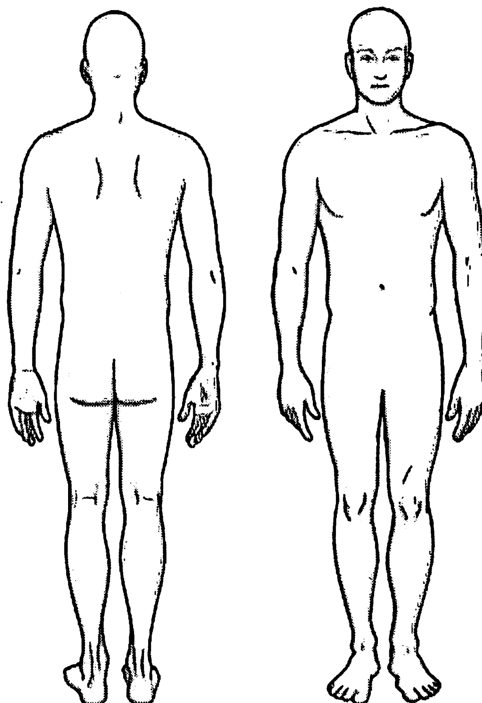
Rate your pain by circling the one number that best describes your pain at its **LEAST in the past 24 hours.**

1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the one number that best describes your pain on **AVERAGE for the past WEEK.**

1 2 3 4 5 6 7 8 9 10

Please note any joint replacements or prosthesis:



The pain is: ❑ sharp ❑ dull ❑ burning ❑ aching ❑ shooting ❑ numbing ❑ stabbing ❑ tingling ❑ comes & goes ❑ constant ❑ deep

With heat, pain is: ❑ worse ❑ better With cold, pain is: ❑ worse ❑ better

With pressure, pain is: ❑ worse ❑ better Pain worse in: ❑ AM ❑ PM

Are you currently taking pain medication? ❑ Yes ❑ No If yes, what medications?________________________________

How often do you take pain medications?____________________ Does your pain disturb your sleep? ❑ Yes ❑ No

Genetic History | Do you, your partner, or anyone in your family have:

- ❑ Neural tube / spina bifida / anencephaly
- ❑ Thalassemia
- ❑ Down Syndrome
- ❑ Cystic Fibrosis
- ❑ Muscular Dystrophy
- ❑ Factor V Leiden
- ❑ Huntington's
- ❑ Mental Retardation/Fragile X
- ❑ Tay-Sachs
- ❑ Sickle Cell disease or trait
- ❑ Hemophilia
- ❑ Hormonal Disorder
- ❑ Hemochromatosis
- ❑ Sjogren's
- ❑ Genetic/Inherited Disorder
- ❑ Chromosomal Disorder
- ❑ Baby with birth defects
- ❑ Infertility

List any significant illnesses in your family:____

Review of Symptoms

Medical History
- ☐ Cancer/Tumor
- ☐ Heart disease
- ☐ Diabetes
- ☐ Congestive heart failure
- ☐ Osteoporosis
- ☐ Autoimmune disease
- ☐ Lupus
- ☐ Rheumatic arthritis
- ☐ Arthritis
- ☐ Hypertension
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ Gout
- ☐ Thyroid disease
- ☐ Depression
- ☐ Other mental illness
- ☐ Alcoholism
- ☐ Drug addiction
- ☐ Bleeding disorders
- ☐ Tuberculosis

Contagious Diseases
- ☐ HIV/AIDS
- ☐ Hepatitis C
- ☐ Hepatitis B

Respiratory
- ☐ Asthma
- ☐ Cough with blood
- ☐ Cough with phlegm
- ☐ Difficulty exhaling
- ☐ Difficulty inhaling
- ☐ Dry cough
- ☐ Allergies
- ☐ Recurrent bronchitis
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Tightness in chest

Cardiovascular
- ☐ History of heart attack
- ☐ History of blood clot
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ High cholesterol
- ☐ Heart palpitations
- ☐ Varicose veins
- ☐ Bruise easily
- ☐ Ankle swelling
- ☐ Leg Cramps
- ☐ Calf pain

Vitamin Levels
- ☐ Vitamin D (result & date)
- ☐ folate (result & date)
- ☐ B12 (result & date)
- ☐ Iron/ferritin (result & date)

Digestion
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Belching
- ☐ Gas
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Difficulty swallowing
- ☐ Heartburn/reflux
- ☐ Bitter taste in mouth
- ☐ Bad breath
- ☐ Ulcers
- ☐ Gallstones
- ☐ Liver disease

Urination
- ☐ Up at night to urinate
- ☐ Burning or painful
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Dribbling
- ☐ Urinary tract infections
- ☐ Poor bladder control
- ☐ Urgency
- ☐ Stones
- ☐ Kidney disease

☐ **Neurologic**
- ☐ Seizures/Epilepsy
- ☐ Strokes
- ☐ Concussion
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Weakness
- ☐ Poor coordination
- ☐ Poor balance
- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Vertigo
- ☐ Tremors

Mouth & Throat
- ☐ Dry mouth or throat
- ☐ Trouble swallowing
- ☐ Swollen glands
- ☐ Tooth problems
- ☐ Gum problems
- ☐ Mouth or tongue sores
- ☐ TMJ clicking or pain
- ☐ Teeth grinding or jaw clenching
- ☐ Drooling at night
- ☐ Dentures
- ☐ Hoarseness

Perspiration
- ☐ Very little or none
- ☐ Occurs without exertion
- ☐ Profuse
- ☐ Night sweats

Skin & Hair
- ☐ Dry
- ☐ Oily
- ☐ Rashes
- ☐ Itching
- ☐ Dark circles around eyes
- ☐ Pimples or acne
- ☐ Spider veins
- ☐ Eczema
- ☐ Psoriasis
- ☐ Brittle nails
- ☐ Prematurely grey hair
- ☐ Dry, brittle hair
- ☐ Hair falling out
- ☐ Dandruff

Eyes, Ears & Nose
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Wear glasses or contacts
- ☐ See spots in vision
- ☐ Poor night vision
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Dry eyes
- ☐ Painful or burning eyes
- ☐ Twitching eyelid(s)
- ☐ Light sensitive eyes
- ☐ Poor hearing
- ☐ Ear aches or infections
- ☐ Ringing (high pitched)
- ☐ Ringing (low pitched)
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Sinusitis

Pain
- ☐ Muscle cramps
- ☐ Muscle spasm
- ☐ Nerve problems
- ☐ Joint pain
- ☐ Stiffness
- ☐ Bone pain
- ☐ Fractures
- ☐ Dislocations

Bowel Habits
- ☐ Loose stool
- ☐ Diarrhea
- ☐ Hard or dry stool
- ☐ Mucus in stool
- ☐ Pain or cramps with BM
- ☐ Blood in stool
- ☐ Undigested food in stool
- ☐ Use laxatives often
- ☐ Hemorrhoids

How often do you have a bowel movement?____

Yes / No — Are you pregnant?

Yes / No — Do you have a pacemaker or ICD?

Emotions
- ☐ Often angry
- ☐ Difficult to express emotions
- ☐ Depressed
- ☐ Often worried
- ☐ Easily irritated
- ☐ Cry easily
- ☐ Stressed or anxious
- ☐ Forgetful
- ☐ Unrestrained joy
- ☐ Over-think everything
- ☐ Indecisive
- ☐ Hyper
- ☐ Restless
- ☐ Sad or grieving
- ☐ Fearful

☐ **Body Temperature**
- ☐ Warm natured
- ☐ Flushed face or cheeks
- ☐ Warm in afternoon or evening
- ☐ Night sweats
- ☐ Cold natured
- ☐ Cold hands and feet

☐ **Males**
- ☐ Prostate problems
- ☐ Impotence
- ☐ Low sex drive
- ☐ Penis discharge
- ☐ Genital sores

☐ **Females**
- ☐ Spotting between periods
- ☐ Irregular periods
- ☐ Heavy periods
- ☐ <25 day cycle
- ☐ >35 day cycle
- ☐ Vaginal discharge
- ☐ Endometriosis
- ☐ Painful periods
- ☐ PMS
- ☐ Breast lumps
- ☐ Low sex drive
- ☐ Uterine prolapse
- ☐ Facial hair
- ☐ Perimenopausal
- ☐ Menopausal

Thyroid
- ☐ TSH thyroid stimulating hormone (result & date)
- ☐ Free T3 (result & date)
- ☐ Free T4 (result & date)
- ☐ Reverse T3 (result & date)
- ☐ TPO/TGAB (for Hashimoto's) (result & date)

Have you ever experienced an emotional, spiritual or physical health incident from which you feel you have never recovered your previous level of health? Please discuss:

Surgeries/Hospitalizations | Please list any hospitalizations, surgeries, fractures, car accidents, or major trauma you have experienced:

- ❑ Appendectomy
- ❑ Biopsies
- ❑ Dental Surgery
- ❑ Gallstones
- ❑ Implants
- ❑ Other
- ❑ Arthroscopy
- ❑ Cholecystectomy
- ❑ Eye Surgery
- ❑ Hysterectomy
- ❑ Kidney Stones
- ❑ Breast Implants
- ❑ C -Section
- ❑ Fracture
- ❑ Hernia
- ❑ Laparoscopy

Briefly list details including date, outcome, etc:

____

____

Medications & Supplements | Please list any medications you are taking, or have taken, and for how long.

Medication	Reason for Taking	Date Started/Stopped	Dosage

Please list any medications you are allergic to:______________________________

Vitamin/Mineral/Supplement/Herbs	Reason for Taking	Date Started/Stopped	Dose (IU/mg)

Energy Level | List on a scale from 1 to 10 (10 being the highest) what your energy levels are during the following times:

Morning 1 2 3 4 5 6 7 8 9 10 Afternoon 1 2 3 4 5 6 7 8 9 10 Evening 1 2 3 4 5 6 7 8 9 10

Late Evening 1 2 3 4 5 6 7 8 9 10 After Meals 1 2 3 4 5 6 7 8 9 10 Overall 1 2 3 4 5 6 7 8 9 10

Stress Level | Rate your current stress level on a scale from 1 to 10 (10 being the highest):

Note that stress can come in forms such as overwork, relationships, health concerns, tiresome family or work responsibilities, trauma, excessive fear, worry, anxiety, insomnia, road rage, not happy with life, etc.

Current Stress Level: 1 2 3 4 5 6 7 8 9 10 Average Stress Level: 1 2 3 4 5 6 7 8 9 10

Main reasons for stress:______________________________

Dietary & Lifestyle Assessment | Please check the boxes in regards to how often you eat or drink the listed types of foods.

	More than Once Daily	Daily	3 Times Weekly	Once Weekly	Twice Monthly	Less or Never
Grains, Breads, Cereals	☐	☐	☐	☐	☐	☐
Milk & Dairy Products	☐	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐	☐
Meat, Poultry, Fish	☐	☐	☐	☐	☐	☐
Beans, Peas & Legumes	☐	☐	☐	☐	☐	☐
Fruits	☐	☐	☐	☐	☐	☐
Vegetables	☐	☐	☐	☐	☐	☐
Soy Products	☐	☐	☐	☐	☐	☐
Nuts & Seeds	☐	☐	☐	☐	☐	☐
Popcorn & Chips	☐	☐	☐	☐	☐	☐
Spicy Foods	☐	☐	☐	☐	☐	☐
Chocolate	☐	☐	☐	☐	☐	☐
Coffee	☐	☐	☐	☐	☐	☐
Tea	☐	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐	☐
Soda	☐	☐	☐	☐	☐	☐
Fast Foods	☐	☐	☐	☐	☐	☐
Sugar & Sweets	☐	☐	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	☐	☐
Recreational drugs	☐	☐	☐	☐	☐	☐

List the **three unhealthiest foods** you eat during a typical week: 1.__________________ 2.____________________ 3.__________________

List the **three healthiest foods** you eat during a typical week: 1.__________________ 2.____________________ 3.__________________

Do you crave certain foods?____

Do certain foods "disagree" with you? ____

Allergies or Sensitivities | Please list any known allergies, including food allergies, environmental, seasonal, etc.

____

____

Are you on a special diet? | Yes ☐ No ☐ | If yes, please check the appropriate boxes and explain in detail your dietary regimen

☐ Atkins	☐ Fruitarian	☐ Low Carb	☐ Pescatarian	☐ Vegetarian
☐ Blood Type Diet	☐ Gerson/Cancer Diet	☐ Low Fat	☐ Raw Food	☐ *Lacto (Dairy OK)*
☐ Dairy Restricted	☐ Gluten Restricted	☐ Low Sodium	☐ South Beach	☐ *Ovo (Eggs OK)*
☐ Diabetic	☐ Jenny Craig	☐ Macrobiotic	☐ Intermittent fasting	☐ *Ovo-Lacto (Eggs & Dairy OK)*
☐ Elimination Diet	☐ Ketogenic	☐ Mediterranean	☐ Vegan	☐ *Part Time*
☐ Food Combining	☐ Kosher	☐ Paleo	☐ Weight Watcher	☐ Other Diet:________________

Please tell us in a few words the reasons for your specific diet, the time duration you have been following the diet, and what results you have experienced by following this diet:

____

____

Exercise | Please check all boxes pertaining your exercise regimen and specify details if necessary:

Do you exercise? ☐ Yes ☐ No

If yes, what type of exercise?

☐ Walking	☐ Pilates	☐ Marathon (full / half / frequency per year:__________)
☐ Running	☐ Dance	☐ Martial Arts (please specify:________________)
☐ Weightlifting	☐ Yoga	☐ Team Sports (please specify:________________)
☐ Spinning	☐ Swimming	☐ Barre
☐ Biking	☐ Cross Fit	☐ Kettle Bell Training
☐ General Cardio	☐ Triathlon	☐ Other:__________________________

How often do you exercise? ☐ 1-2 times per week ☐ 3-4 times per week ☐ 5 or more times per week

How long is your average exercise session? (circle one): 30min 60 min 90 min over 90 min

Do you train for any competition? If yes, please explain:____

Sleep | Rate your sleep quality. Check all that apply:

☐ Restful sleep	☐ Wake up rested	☐ Nightmares	☐ Bruxing	☐ Other:______________________
☐ Restless sleep	☐ Wake up tired	☐ Sleep Apnea	☐ Restless Legs	
☐ Difficulty falling asleep	☐ Vivid Dreams	☐ Snoring	☐ Wake up during the night (usual time of waking:_________)	

What time do you usually go to sleep? ________________ How many hours do you sleep per night on average? _________________

Thank you for providing such detailed information. Each piece you provide helps in better understanding the path you have been on up to the outset of your treatments. If there is anything you wish to bring to our attention which is not asked on this form, please note below:

Female Fertility

Date last menses (period) began ______________	At what age did you have your first menstruation? ____________
Is your menstrual cycle – Regular ____ Irregular ____ ?	Do you ovulate on your own? Yes No Unsure
How long is your typical cycle? (i.e. 24 – 30 days) _______ days	Do you experience pain around ovulation? Yes No
How many days do you bleed in total? ____________	Do your breasts get tender around ovulation? Yes No
Circle what describes your flow, the consistency and color of the blood:	Do you chart your cycle? No / BBT / Ovulation sticks / Other
Heavy | Moderate | Light Watery | Moderate | Thick	Do you notice stretchy, slippery, clear, egg white-like mucous around ovulation? Yes | No | Unsure
Dark Red | Red | Brownish Red | Brown | Purple | Pink	
At which point in the cycle does your blood contains clots?	Have you noticed discharge from your nipples? Yes No
Never | Start | Midpoint | End	Do you experience any of these **PMS** symptoms? circle
How large are the clots? Pea | Dime | Inch | Golf Ball	Breast tenderness | Cramps | Nausea
Do you experience menstrual pain? No | Before | During | After	Fatigue | Acne | Moodiness
Is the pain: Stabbing | Cramping | Dull Ache | Heavy | On/Off	Headaches | Bloating | Change in bowel
What relieves your pain?	Sleep disturbances | Night sweats | Other:

Fertility history:

Have you had any miscarriages or stillborn births? Yes No	How many times have you been pregnant?
If yes above, how many and number of weeks pregnant:	How many times have you given birth? Age(s) of child(ren):
	Vaginal Delivery | C-Section | Premature _____ weeks
How many times have you had a D&C performed?	Other problems during pregnancies:
How many abortions have you had? In what year(s)?	Have you had any tubal operations? Yes No
Which forms of chemical contraception have you used, for how long and when did you stop?	Have you taken medication to help you ovulate? Yes No
	What kind? For how many cycles?
Oral ________/_________ Depo-Provera _______/________	Have you had your uterine/fallopian tubes evaluated medically? Yes No
IUD ________/__________ Other:	If yes, what were the results?

Have you had any hormone lab tests performed? Please indicate the results.

FSH	Value	High	Normal	Low	Thyroid	Value	High	Normal	Low
Estrogen, E2	Value	High	Normal	Low	Testosterone	Value	High	Normal	Low
Progesterone	Value	High	Normal	Low	MTHFR		No	Yes	
Prolactin	Value	High	Normal	Low	AMH	Value	High	Normal	Low
NK cells	Value	High	Normal	Low	Other	Value	High	Normal	Low

Have you ever been diagnosed with: (please circle)			**Gynecological history:**
Pelvic Inflammatory Disease	Yes	No	Date of your last pap smear ________________
Uterine fibroids	Yes	No	Have you ever had an abnormal pap smear? Yes No
Polyps	Yes	No	Have you ever had a cervical biopsy or operation? Yes No
Pelvic adhesions	Yes	No	Do you get yeast infections frequently? > 4x/year Yes No
Prolapsed uterus	Yes	No	Do you get bladder infections or UTIs frequently? Yes No
Endometriosis	Yes	No	Do you experience vaginal discharge? Yes No
PCOS (polycystic ovarian syndrome)	Yes	No	If yes, please describe color, consistency and odor:
Unique shape of uterus	Yes	No	White | Yellow | Green | Pink | Red
STD	Yes	No	Thin/Watery | Thick | Sticky
If yes, please list STDs:			

Do you have a partner with whom you have been trying to conceive? Yes No	What is his / her name?
How long have you been married or living together?	Is he / she supportive of your wish to conceive? Yes No
Describe your relationship:	
Have either of you had a Western medical diagnosis relating to fertility? Yes No If yes, when?	How long have you been trying to conceive?
If yes, please describe the diagnosis for her -	For him -
Have you ever undergone assisted reproductive fertility treatments? (IUI, IVF) Yes No	

	Clinic	Month / Year	Type of treatment (details next section)

# of cycles	Treatment Type	Date From (mo/yr) to (mo/yr)	Outcome
	Intrauterine insemination (IUI) Natural	to	___Pregnant: Delivered/ Ectopic/ Miscarriage; ___Not pregnant
	IUI Clomid/Letrozole	to	___Pregnant: Delivered/ Ectopic/ Miscarriage; ___Not pregnant
	IUI Injectibles	to	___Pregnant: Delivered/ Ectopic/ Miscarriage; ___Not pregnant
	Timed intercourse	to	___Pregnant: Delivered/ Ectopic/ Miscarriage; ___Not pregnant
	___Completed in vitro fertilization (IVF) cycle(s) 1. # eggs ____; # embryos transferred____; #frozen____ 2. # eggs ____; # embryos transferred____; #frozen____ 3. # eggs ____; # embryos transferred____; #frozen____	to	___Pregnant: Delivered/ Ectopic/ Miscarriage; ___Not pregnant ___Pregnant: Delivered/ Ectopic/ Miscarriage; ___Not pregnant ___Pregnant: Delivered/ Ectopic/ Miscarriage; ___Not pregnant
	___Frozen embryo transfers 1. # embryo transferred_____ 2. # embryo transferred_____ 3. # embryo transferred_____	to	___Pregnant: Delivered/ Ectopic/ Miscarriage; ___Not pregnant ___Pregnant: Delivered/ Ectopic/ Miscarriage; ___Not pregnant ___Pregnant: Delivered/ Ectopic/ Miscarriage; ___Not pregnant
	___Canceled IVF attempt(s)	to	

___Any other prior treatment (describe):		
Have you done LIT or IVIG? Yes No Currently	Have you done Intralipids? Yes No Currently	
Have you taken Lovenox or Heparin? Yes No Currently	Have you taken Prednisone or Steroids? Yes No Currently	Have you taken Metformin? Yes No Currently
Are you using donor sperm? Yes No If yes, why? Female partner | male partner had semen issues | other		
Rate your level of sexual desire (mental interest) Low | Average | High	Has this level changed? Decreased | Increased | Unchanged	
What is your orgasm frequency/ intensity? Low | Average | High	Has this level changed? Decreased | Increased | Unchanged	
Do you use vaginal lubricants? Yes No	Have you been exposed to or received chemotherapy/radiation? No Yes If yes, when?	
Do you have oily skin? Yes No		
Do you have excessive facial / body hair? Yes No	Height ______ ft _______ in Weight __________ lbs	

Thank you for providing such detailed information. Each piece you provide helps in better understanding the path you have been on up to the outset of your treatments. If there is anything you wish to bring to our attention which is not asked on this form, please note below:

Male Fertility

How long have you and your partner been trying to conceive?		Height ______ ft ______ in	Weight ________ lbs
How would you describe your sexual energy?		☐ Below normal	☐ Normal
Have you had a recent physical exam?		☐ Yes ☐ No	
Do you or did you have an undescended testicle?		☐ Yes ☐ No	
Have you been diagnosed with a varicocele?		☐ Yes ☐ No	
Have you ever had any urologic surgeries?		☐ Yes ☐ No	
Hove you experienced erectile dysfunction?		☐ Yes ☐ No	
Have you had difficulty ejaculating?		☐ Yes ☐ No	
Have you had exposure to any known environmental toxins or hormones?		☐ Yes ☐ No	
Have you experienced any penile discharge?		☐ Yes ☐ No	
Do you regularly experience nocturnal emission?		☐ Yes ☐ No	
Do you have high cholesterol?		☐ Yes ☐ No	
Have you experienced a high fever (above 101) in the last 6 months?		☐ Yes ☐ No	
Do you currently have any prostate conditions?		☐ Yes ☐ No	
Do you or have you ever had urinary infections or STDs?		☐ Yes ☐ No	
Have you ever taken testosterone supplements / drugs?		☐ Yes ☐ No	
Have you had your testosterone levels checked recently?		☐ Yes ☐ No	
Have you been tested for sperm antibodies?		☐ Yes ☐ No	
Have you been diagnosed with small or soft testis?		☐ Yes ☐ No	
Have you ever fathered any prior pregnancies?		☐ Yes ☐ No	Outcome:
Have any of your immediate family members had difficulty conceiving a child?		☐ Yes ☐ No	
Have you been checked for a blockage of your reproductive tract?		☐ Yes ☐ No	
Have you had a fertility workup?		☐ Yes ☐ No	
If yes, what was your sperm count?	Number: ______________	☐ Below normal	☐ Normal
What was the sperm motility?	______________	☐ Below normal	☐ Normal
What was the sperm morphology?	______________	☐ Abnormal	☐ Normal

Do you have a partner with whom you have been trying to conceive? Yes No	What is his / her name?
How long have you been married or living together?	Is he / she supportive of your wish to conceive? Yes No
Describe your relationship:	
Have either of you had a Western medical diagnosis relating to fertility? Yes No If yes, when?	How long have you been trying to conceive?
If yes, please describe the diagnosis for her -	For him -
Have you ever undergone assisted reproductive fertility treatments? (IUI, IVF) Yes No	

Clinic	Month / Year	Type of treatment	Results

Are you using donor sperm? Yes No If yes, why? Female partner | male partner had semen issues | other	
Rate your level of sexual desire (mental interest) Low | Average | High	Has this level changed? Decreased | Increased | Unchanged
What is your orgasm frequency/intensity? Low | Average | High	Has this level changed? Decreased | Increased | Unchanged
Have you been exposed to or received chemotherapy/radiation? No Yes If yes, when?	
Height ______ ft ______ in Weight ________ lbs	

Thank you for providing such detailed information. Each piece you provide helps in better understanding the path you have been on up to the outset of your treatments. If there is anything you wish to bring to our attention which is not asked on this form, please note below:

Traditional Chinese Medicine Patterns

	KIDNEY YIN DEFICIENCY
☐	1. Do you have lower back weakness, soreness, or pain, or knee problems?
☐	2. Do you have vaginal dryness?
☐	3. Is your mid-cycle fertile cervical mucus scanty or missing?
☐	4. Do you have night sweats?
☐	5. Are you prone to hot flashes or feeling heat in your palms, chest and soles?
☐	6. Is your cycle usually shorter than 28-32 days?
	KIDNEY YANG DEFICIENCY
☐	1. Have you been diagnosed with hypothyroidism?
☐	2. Is your low back or knees sore or weak?
☐	3. Are your feet cold and hands cold?
☐	4. Is your libido low?
☐	5. Do you have profuse vaginal discharge?
☐	6. Does your cycle last longer than 32 days usually?
☐	7. Do you gain weight easily?
☐	8. Have you been diagnosed with low progesterone levels?
☐	9. Do you have spotting before you bleed?
☐	10. Do you have profuse vaginal (odorless) discharge, especially mid-cycle?
	SPLEEN QI DEFICIENCY
☐	1. Are you often fatigued? Too tired to exercise? Feel heavy or sluggish?
☐	2. Is your energy lower after a meal or are you bloated after eating?
☐	3. Do you have loose stools, abdominal pain, or digestive problems?
☐	4. Are your hands and feet cold? Nose?
☐	5. Do you bruise easily?
☐	6. Do you think you have poor circulation?
☐	7. Have you been diagnosed with low blood pressure?
☐	8. Is your menstruation thin, watery, profuse, or pinkish in color?
☐	9. Do you ever spot a few days or more before your period comes?
☐	10. Are your menstrual cramps accompanied by a bearing-down sensation in your uterus?
☐	11. Are you often sick, or do you have allergies?
☐	12. Have you been diagnosed with hypothyroid or anemia?
☐	13. Do you have hemorrhoids or polyps?
	BLOOD DEFICIENCY
☐	1. Are your menses scanty and/or late?
☐	2. Do you have dry skin, hair or nails?
☐	3. Are you losing hair on your head (not in patches but all over?)
☐	4. Are you often thirsty?
☐	5. Are you always tired and/or mildly depressed?
☐	6. Are you bowel movements hard/dry or are you frequently constipated?
☐	7. Do you need vaginal lubricants?
	HEART DEFICIENCY
☐	1. Do you wake up early in the morning and have trouble getting back to sleep?
☐	2. Do you have heart palpitations, especially when anxious?
☐	3. Do you have nightmares?
☐	4. Do you feel low in spirit or lacking in vitality?
☐	5. Are you prone to agitation or extreme restlessness? Do you fidget?

	EXCESS HEAT
☐	1. Are your mouth and throat usually dry?
☐	2. Are you thirsty for cold drinks most of the time?
☐	3. Do you often feel warmer than those around you?
☐	4. Do you wake up sweating or have hot flashes?
☐	5. Do you break out with red acne (especially premenstrually)?
☐	6. Do you have a short menstrual cycle?
☐	7. Do you commonly have vaginal irritation or rashes?
☐	8. Is your blood flow during your menses unusually heavy?
	DAMPNESS
☐	1. Do you feel tired and sluggish after a meal?
☐	2. Do you have lumps in your breasts?
☐	3. Do you have cystic or pustular acne?
☐	4. Do you have urgent, bright, or foul-smelling stools?
☐	5. Are you prone to yeast infections and vaginal itching?
☐	6. Do your joints ache, especially with movement?
☐	7. Are you overweight?
☐	8. Are your periods irregular or delayed?
☐	9. Do you have excessive clear, watery vaginal discharge?
	DAMP HEAT
☐	1. Do you have foul-smelling, yellow, or greenish vaginal discharge?
☐	2. Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase?
	LIVER QI STAGNATION
☐	1. Are you prone to emotional depression, anger or rage?
☐	2. Do you become irritable or bloated premenstrually? Around ovulation?
☐	3. Are your breasts sensitive/sore at ovulation? premenstrually?
☐	4. Have you been diagnosed with elevated prolactin levels?
☐	5. Do you have difficulty falling asleep at night?
☐	6. Do you commonly experience heartburn or wake up with a bitter taste in your mouth?
☐	7. Are your menses painful?
☐	8. Is the menstrual blood thick and dark, or purplish in color?
	BLOOD STASIS
☐	1. Is your menstrual flow ever brown or black in color?
☐	2. Do you feel midcycle pain around your ovaries?
☐	3. Do you have varicose or spider veins?
☐	4. Does your menstrual blood contain clots?
☐	5. Have you been diagnosed with endometriosis or uterine fibroids?
☐	6. Do you have piercing or stabbing menstrual cramps?
☐	7. Are your periods irregular (varying in length of cycle)?
☐	8. Have you been diagnosed with any vascular abnormality or blood clotting disorder?

Thank you for providing such detailed information. Each piece you provide helps in better understanding the path you have been on up to the outset of your treatments. If there is anything you wish to bring to our attention which is not asked on this form, please note below: