YIN AND TONIC

Health History Form

Please complete this questionnaire as thoroughly as possible. Successful healthcare and preventative medicine are only possible when the practitioner has a complete understanding of the patient's physical, mental, and emotional states. Print all information and indicate areas of confusion with a question mark. All of your answers are completely confidential. Thank you.

Name: _____ Date: _____/_____/_____
First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ May we contact you via e-mail? Y / N

Cell Phone: _____ Home Phone: _____ Work Phone: _____

May we contact you by phone and leave a message if necessary? Y / N If yes, at which phone number? _____

Date of Birth: _____/_____/_____ Age: _____ Gender: _____ Marital Status: _____ Height: _____ Weight: _____

Occupation: _____ Hours of work per week: _____

Do you enjoy your work? Y / N Why or why not? _____

Have you received acupuncture before? Y / N If so, when and with whom? _____

Emergency Contact: _____
Name Relationship Telephone

Who can we thank for referring you? _____

Please identify the health concerns for which you are seeking treatment in order of importance below:

Condition	**Past Treatment**	**Date Began**
a. _____	_____	_____

How does this condition affect you? _____

Please note the severity of your problem right now:

|_____|
No Problem Worst Imaginable

b. _____ _____ _____

How does this condition affect you? _____

Please note the severity of your problem right now:

|_____|
No Problem Worst Imaginable

Please list any foods, drugs, or medications you are hypersensitive or allergic to, including your reaction:

_____

_____

_____

Please list all medications (prescribed or over-the-counter), vitamins, or supplements you are currently taking (continue on back of page, if necessary):

Medication	Dosage	Condition	How long?	Prescribed by

Have you had any courses of antibiotics recently? ☐ Many ☐ A few ☐ 1 or 2 ☐ None

Please indicate if you are taking any of the following:

☐ blood thinners (warfarin, Coumadin, etc.) ☐ diet pills (diuretics, appetite suppressants, etc.)
☐ pain relievers (Tylenol, aspirin, etc.) ☐ cortisone or other steroids ☐ thyroid medication
☐ tranquilizers/sedatives ☐ sleeping aids ☐ laxatives ☐ antacids (Tums, etc)

Do you have any reason to believe you may be pregnant? Y / N If so, how far along are you? _____

Do you have any infectious diseases? Y / N If yes, please identify: _____

Please list any hospitalizations and surgeries:

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____

Childhood Illness: __ Chicken Pox __Diphtheria __ German Measles __ Measles __ Mumps __Rheumatic Fever

__Scarlet Fever Other: _____

Sexually Transmitted Infections: __Chlamydia __Gonorrhea __Herpes __HIV __HPV __Syphilis

Please indicate if any of the following pertain to you:

(Marking "yes" does not make you ineligible for treatment, however, it may restrict some of the treatment modalities used)

☐ Hepatitis (A,B,C) ☐ High Blood Pressure ☐ History of Seizures ☐ Currently/Potentially Pregnant
☐ Bleeding Disorder ☐ Neruropathy ☐ Needle Phobia ☐ Multiple Sclerosis

Please indicate which of the following symptoms you experience. Use a checkmark (✓) for the ones you experience occasionally and a plus sign (+) for the ones you experience frequently.

__ Belching./burping
__ Bloating
__ Blood in stools
__ Craving sweets
__ Diarrhea/loose stools
__ Easy bruising or bleeding
__ Edema
__ Excessive appetite
__ Feel full quickly
__ Feeling of food retained in stomach
__ Foggy brain
__ Heartburn/acid reflux
__ Heaviness in limbs
__ Lack of appetite
__ Mucus in stools
__ Nausea
__ Obsessive or overthinking
__ Tarry stools
__ Tendency to gain weight
__ Tired after eating
__ Vomiting

__ Angina pains
__ Easily startled
__ Heart palpitations
__ Insomnia/difficulty sleeping
__ Lack of joy in life
__ Laughing for no apparent reason
__ Mentally restless
__ Nightmares/vivid dreams
__ Sensation of heat in the chest

__Acne
__ Allergies
__ Asthma
__ Bronchitis
__ Colitis/diverticulitis
__ Cough
__ Coughing up phlegm
__ Dry mouth, nose, throat
__ Frequent colds/flu
__ Grief/sadness
__ Hemorrhoids
__ Hives
__ IBS/Crohn's Disease
__ Nasal discharge
__ Post nasal drip
__ Red, itchy, painful throat
__ Shortness of breath
__ Skin rashes
__ Sneezing
__ Snoring

__ Blurred vision/floaters
__ Clench teeth at night
__ Difficulty digestion oily foods
__ Difficulty making decisions
__ Dizziness/lightheadedness
__ Easily angered/irritable
__ Gallstones
__ Jaundice
__ Light colored stools
__ Neck/back/shoulder tension/pain
__ Spasms or muscle twitches

__ Craving salty food
__ Dry hair/skin
__ Ear ringing
__ Excessive sex drive
__ Feels cold easily
__ Feels fearful
__ Feels lump in throat
__ Hair loss
__ Hearing impairment
__ Hot flashes
__ Kidney stones
__ Knee pain
__ Low back pain
__ Low sex drive
__ Night sweats
__ Nighttime urination
__ Poor memory, forgetful
__ Soft/brittle nails
__ Urinary problems

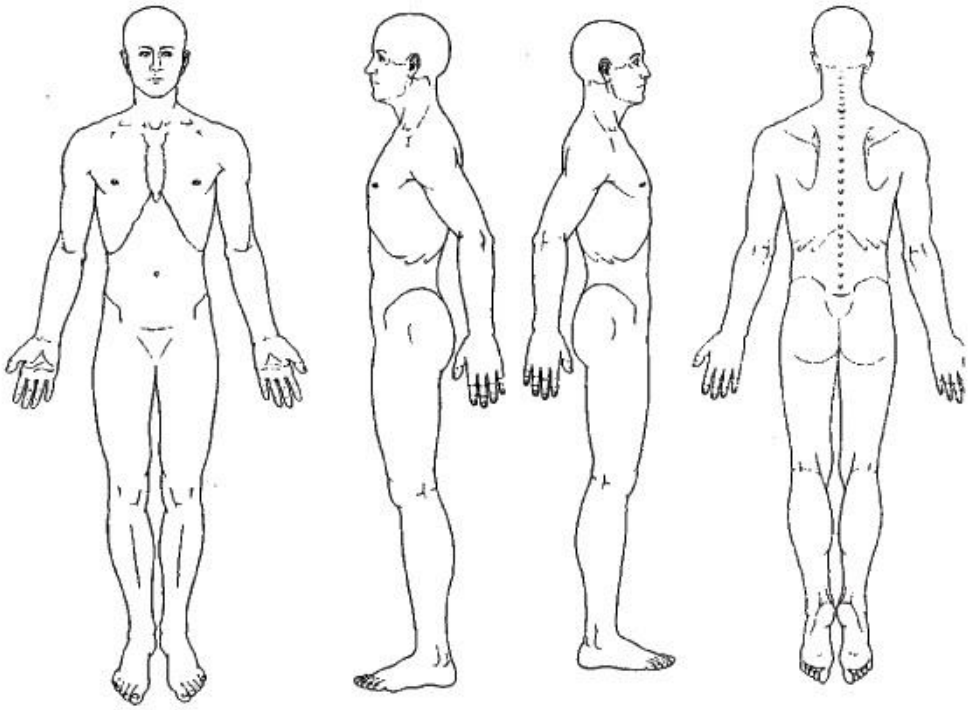
Family History: Please check (✓) those applicable and indicate year of diagnosis.

	You	Father	Mother	Brothers	Sisters
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Seizures/Epilepsy	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____

Musculoskeletal

__ Back pain	__ Hand/wrist pain	__ Muscle pain	__ Sciatica
__ Bursitis	__ Hip pain	__ Muscle weakness	__ Shoulder pain
__ Carpal tunnel	__ Knee pain	__ Neck pain	__ Sprains/strains
__ Foot/ankle pain	__ Limited range of motion	__ Rotator cuff problems	__ Tendonitis

Please mark any area(s) of injury, pain, or discomfort on the figure to the right. Indicate the severity with a number from 1 (mild) to 10 (excruciating) and indicate the quality with the following symbols:
AAA: aching
BBB: burning
NNN: numbness
PPP: pins & needles
SSS: stabbing



Lifestyle:

For the following substances please indicate type and average amount of current and/or past use (if applicable):

Caffeine: _____

Nicotine: _____

Alcohol: _____

Recreational Drugs: _____

Type(s) and amount(s) of exercise each week: _____

_____

Average hours of sleep per night: _____ Do you wake rested? Y / N Problems falling or staying asleep? Y / N

If yes, please describe: _____

Please circle your stress level: Low Medium High

What are your primary sources of stress? _____

Have you experienced any major traumas (i.e. abuse, major accidents, death of spouse/partner, etc.)? Y / N

If yes, please describe: _____

_____

_____

Is there anything else you would like us to know? _____

_____

_____

_____

FOR MEN

Date of last prostate checkup: _____ PSA result: _____

Frequency of urination: Daytime _____ Nighttime _____ Urine: Clear ____ Cloudy ____Odor _____

__ Back Pain	__ Discharge/Sores	__ Lumps/Masses near Testicles	
__ Blood in urine	__ Dribbling after urination	__ Kidney stones	__ Rectal dysfunction
__ Burning on urination	__ Groin pain	__ Nocturnal emission	__ Retention of urine
__ Copious urine flow	__ Impotence	__ Pain in testicles	__ Scanty urine flow
__ Decreased libido	__ Incontinence	__ Pain on urination	__ Urgent urination
__ Delayed stream	__ Increased libido	__ Premature ejaculation	__ Urinary tract infection

Are you sexually active? _____

FERTILITY

When was your last sperm count? _____

What were the results? (Please circle)

Volume	Low		Medium			High			_____ml
Concentration	Low		Medium			High			_____ml
Count	Low		Medium			High			_____million
Motility Grade	1	1+	2	2+	3-	3	3+	4	
Forward Progression	_____%								
Morphology	_____% with normal morphology								

Other test results

_____

_____

_____

_____

FOR WOMEN

Are you still menstruating? _____ Age menses began: _____ Date of last period: _____

Are you now pregnant? _____ Date of your last ob/gyn exam: _____

# of live births: ____ Total # of pregnancies: _____ #of miscarriages: _____ # of terminations: _____

Pregnancy	Year	Length of pregnancy	Hours of labor	Type of delivery	Sex	Weight	Complications	Meds during labor/delivery?
First								
Second								
Third								
Fourth								

Are you sexually active? _____ STDs?_____

What birth control do you currently use? _____ How long have you used it? _____

What other types of birth control have you used in the past? _____

Do you experience any sexual difficulties? (please describe) _____

Do you experience any of the following?

	Occasional	Frequent		Occasional	Frequent
Endometriosis			Fibrocystic breasts		
Ovarian cysts			Breast cancer		
Uterine fibroids			Breast lumps		
Abnormal pap smear			Nipple discharge		
Yeast infections			Vaginal discharge/odor		
Urinary tract infections			Herpes		
Pain/itching of genitalia			HPV (human papilloma virus)		
Genital lesions/discharge			Hysterectomy		
PID (pelvic inflammatory disease			Uterine prolapse		

# of days between periods: _____ # of days you bleed: _____ Do you bleed between periods? _____
Do you bleed ❑ heavy ❑ moderate ❑ light ❑ very little

Have your periods changed since they started? yes no
When?_____Why? _____

What color is your menstrual blood (check all that apply)

❑ Pale pink/red ❑Red ❑ Bright Red ❑ Dark red ❑ Dark red/brown ❑ Black ❑ Dark purple

# of pads/tampons used: ___ day 1 ___ day 2 ___ day 3 ___ day 4 ___ day 5 ___ day 6+

On your heaviest day, which do you use? (please circle) ❑ Regular ❑Super ❑Super plus

How often do you change your pad/tampon?
❑ Every hour or less ❑ Every two hours ❑ Every 4 hours ❑ I don't really need to change my pad or tampon, but I do for hygiene Other:_____

Are your periods painful? ❑ before period ❑ during period ❑ after period

Is the pain ❑ mild ❑ moderate ❑ severe

Is the pain located in: ❑ low abdomen ❑ low back ❑ thighs ❑ other _____

Is the quality of the pain ❑ cramping ❑ stabbing ❑ aching ❑ dull ❑ burning ❑ constant ❑comes and goes

Do you pass clots? (please circle) yes no

What color are the clots?
❑ Bright Red ❑ Dark red ❑ Brownish ❑ Black ❑Dark purple ❑Mucus

How big are the clots on average?
❑ Small stringy ❑ Small and spotty ❑ The size of a dime ❑ The size of an egg yolk ❑ The size of your fist

Do you experience pain with the passing of your clots? (please circle) yes no n/a

Do you feel better after passing clots? (please circle) yes no n/a

Please indicate if you experience the following in relation to your menses (before (B), during (D), after (A)):

__ Bloating	__ Discharge	__ Insomnia	__ Poor appetite
__ Constipation	__ Headache	__ Mood swings	__ Ravenous appetite
__ Decreased libido	__ Hot flashes	__ Nausea	__ Swollen breasts
__ Diarrhea	__ Increased libido	__ Night sweats	__ Vaginal dryness

Other symptoms related to your period:

	Occasional	Frequent		Occasional	Frequent
Discharge			Swollen or painful breasts		
Headaches			Mood swings		
Nausea			Increased appetite		
Constipation			Decreased appetite		
Diarrhea			Insomnia		
Cravings					

Is there anything else you would like us to know?

OVULATION

On what cycle day do you ovulate?_____
Do you use an ovulation predictor kit to determine ovulation? _____
Do you chart your Basal Body Temperature? yes no

Do you experience any symptoms at ovulation?
❑ Breast tenderness ❑ Sharp pain ❑ Cramping ❑ Bowel movement changes ❑ Irritability/rage

Do you get cervical mucus at ovulation? yes no For how many days?_____
Describe the quality/quantity of your cervical mucus:
❑ None, I never notice any even with internal exam ❑ Scant, I only notice it with internal exam
❑ Moderate, I notice some on my underwear and when I urinate
❑ Profuse, I notice large amounts in my underwear and when I urinate
❑ Creamy, thick ❑ Like rubber cement ❑ Egg white stretchy ❑ Watery ❑ Other

Do you notice cervical mucus at other times during your cycle? yes no

If yes, when?_____For how many days?_____

What is the quality of that mucus?_____

FERTILITY INFORMATION

How long have you been trying to get pregnant?_____

Has a physician diagnosed a difficulty with fertility due to:
❑ Female factor ❑ Male factor ❑ Unexplained
Other_____
Who is your Ob-Gyne, or Reproductive Endocrinologist?

Have you had any testing relating to your fertility?
Hormone levels:
ESTRADIOL_____FSH_____LH_____ ESTROGEN_____PROGESTERONE_____

Other blood tests: _____

Laparascopy:_____

HSG(test to determine state of fallopian tubes):_____

Ultrasound:_____

Any uterine abnormalities?_____

Have you taken any medication relating to your fertility?_____

Number of IVF procedures?_____ Number of IUIs_____

What are your treatment goals relating to your fertility?

How would you describe the emotions most closely related to your journey towards pregnancy?