ACUPUNCTURE AND INTEGRATIVE MEDICINE ASSOCIATES OF NASHUA PLLC
CLINICAL EXCELLENCE AND COMPASSIONATE CARE SINCE 1992

PATIENT HEALTH HISTORY INTAKE FORM

WELCOME!

At Acupuncture and Integrative Medicine Associates of Nashua, we value integrity, clinical excellence and compassionate care. There is no higher honor than to be given the privilege of applying our skills to assist you in your well-being. While under our care, you will be treated as a unique individual, with a treatment plan that is specifically tailored to your concerns and adjusted as needed in accordance with your progress. We utilize an integrative approach that incorporates the strengths of both Western (also known as conventional or allopathic medicine) and Asian medicine. We believe in collaboration between doctors and patients, the practice of self care and a balance between work, rest and leisure in maintaining health. We look forward to working with you!

Please help us to provide you with a comprehensive and individualized evaluation by filling out this questionnaire. Mark any check boxes that apply now or in the past. Thank you in advance in assisting us with a thorough intake.

Date Today:_____ Date of Appointment: _____
Full Legal Name: _____
Preferred Name: _____
Date of Birth: _____Age: _____Gender: _____
Home Phone:_____Work Phone: _____
Cell Phone: _____ Other Phone:_____
Preferred Phone (best way to contact you?):_____
RESIDENTIAL ADDRESS: Street, City, State, Zip Code:_____
_____
MAILING ADDRESS: Street, City, State, Zip Code:_____
_____
Preferred email contact: (Best email address to use)? _____
Name of primary care provider and credentials (MD, DO, NP/ARNP/APRN, PA-C, etc.):
_____
Primary care provider phone: _____Fax: _____
Address of primary care provider (Practice name, Street, City, State, Zip Code):
_____
_____
Date of last physical exam: _____

Names of other health care provider(s), as applicable:

☐Acupuncturist:_____ ☐PT:_____
☐OT: _____ ☐Chiropractor: _____
☐ Athletic Trainer:_____ ☐Massage Therapist: _____
☐Naturopathic doctor: _____ ☐Dietician or nutritionist: _____
☐Psychiatrist:_____ ☐Psychologist:_____
☐Counselor:_____ ☐Neurologist:_____
☐Orthopedist:_____ ☐Sports Medicine: _____
☐Rheumatologist:_____ ☐Cardiologist:_____
☐Endocrinologist:_____ ☐Gastroenterologist: _____
☐Pulmonologist:_____ ☐Hematologist:_____
☐Allergist:_____ ☐ENT:_____

□Dermatologist: _____ □Surgeon:_____
□Oncologist: _____ □Urologist:_____
□OB/GYN:_____ □Physiatrist _____
□Pain Medicine: _____ □Geriatrician:_____
□Pediatrician:_____ □Ophthalmologist: _____
□Other/Not Listed: _____

May we share this information with your health care provider(s)?

□Yes - Share everything; I want the benefit of collaborative care between my health care providers
□Yes - You may share the information specified on my PHI (Protected Health Information) Release Form
□No

How did you hear about us? (Check all that apply) □Primary care provider □Another provider □A local business □Rotary Club □Chamber of Commerce □Government agency □Friend □Friend of a friend □Co-worker □Neighbor □Associate □ Patient of yours □Employer □Internet Search □Google Reviews □Yelp Reviews □Social Media □ Other/Not Listed**:**_____

Emergency Contact (first and last name):_____
Emergency contact relation to you:_____
Emergency contact phone numbers (cell, work, home): _____
_____

Have you ever been treated with acupuncture, Asian medicine, or Chinese herbal medicine? □Yes □No
*If yes - how long ago, with whom, what for, and how was the experience?_____

Main reason for your visit today: □Preventative care □Wellness visit □New concern(s) □Ongoing problem(s)

PRIMARY HEALTH CONCERNS

Please describe the top three health concerns you would like to address.

1. *What is the first concern or problem, and how long ago did it begin?* (Give a specific date, or a range of weeks, years, or months): _____
Please describe the specific incident that marked the beginning of this concern or problem, or information about when you first noticed it: _____
_____
What makes it better or worse? Please list any alleviating or aggravating factors:_____
_____
How does this impact you (physically or psychologically)? What would you like to be able to do that you have difficulty with, or cannot do?_____

2. *What is the second concern or problem, and how long ago did it begin?* (Give a specific date, or a range of weeks, years, or months): _____
Please describe the specific incident that marked the beginning of this concern or problem, or information about when you first noticed it: _____
_____
What makes it better or worse? Please list any alleviating or aggravating factors: _____
_____
How does this impact you (physically or psychologically)? What would you like to be able to do that you have difficulty with, or cannot do?_____

3. *What is the third concern or problem, and how long ago did it begin?* (Give a specific date, or a range of weeks, years, or months): _____

Please describe the specific incident that marked the beginning of this concern or problem, or information about when you first noticed it: _____

_____

What makes it better or worse? Please list any alleviating or aggravating factors:_____

_____

How does this impact you (physically or psychologically)? What would you like to be able to do that you have difficulty with, or cannot do?_____

Have you been given a diagnosis for any of these problems or concerns? □Yes □No *If yes - What diagnosis(es), how long ago, and by whom?_____

What self care or other treatments have you tried? _____
How effective were they? □Not at all □Poor □Fair □Good □Excellent *Tell us more about what treatments offer no help, have some effect, or help a lot: _____

TREATMENT GOALS: What would you like the outcome of this treatment to be? List one, two, or three goals:
1. _____
2. _____
3. _____

Past Medical History (Check all that apply to YOU): □Heart disease □Kidney disease □Liver disease □Lung disease □COPD □Autoimmune disease □Cancer □Diabetes □Stroke □TIA/transient ischemic attack □Blood clots □Seizures □Blood disorder □Bruise easily □Bleeding disorder □Anemia □Varicose veins □High blood pressure □Asthma □Low blood pressure □High cholesterol □High blood sugar □Low blood sugar □Arthritis □Anxiety □Depression □Thyroid disease/Hyperthyroidism □Thyroid disease/Hypothyroidism □Osteopenia □Osteoporosis □Mental Illness □Eating disorder □Trauma/abuse □Drug/alcohol abuse □Neurological disorder □Other/Not Listed *Please share details regarding any of the above:*_____
Have you ever been hospitalized? □Yes □No *If yes, what for, when, and for how long? _____

_____

Have you had any surgeries? □Yes □No *If yes, what for and when?_____

_____

Family Medical History (Check all that apply to YOUR FAMILY - mother, father, siblings, grandparents):
□Heart disease □Kidney disease □Liver disease □Lung disease □COPD □Autoimmune disease □Cancer □Diabetes □Stroke □TIA (transient ischemic attack) □Blood clots □Blood disorder □Bruise easily □Asthma □Bleeding disorder □Anemia □Varicose veins □Seizures □High blood pressure □Low blood pressure □Anxiety □High blood sugar □Low blood sugar □Thyroid disease/Hyperthyroidism □Thyroid disease/Hypothyroidism □Depression □Osteopenia □Osteoporosis □Arthritis □High cholesterol □Mental Illness □Eating disorder □Trauma/abuse □Drug/alcohol abuse □Neurological disorder □Other/Not Listed *Please share details regarding any of the above:* _____

MEDICATIONS, SUPPLEMENTS, VITAMINS, AND TOPICAL PREPARATIONS

Please list all current medications, supplements, vitamins, creams, ointments, powders, topical preparations, both prescription and over the counter. Please include instructions for use (morning/evening, once daily, etc.) and dosage:

_____

_____

_____

_____

ALLERGIES AND SENSITIVITIES

Do you have an allergic reaction or sensitivity to latex? □Yes □No

Do you have an allergic reaction or sensitivity to adhesives (such as those used with medical tape, bandages, or adhesive strips)? □Yes □No
Please list any known drug allergies or sensitivities:_____
_____
Please list any known chemical allergies or sensitivities: _____
_____
Please list any known seasonal allergies or sensitivities: _____
_____
Please list any known environmental allergies or sensitivities: _____
_____
Please list any known food allergies or sensitivities: _____
_____

Your current height:_____ feet _____ inches **Your current weight**: _____ pounds

GENERAL SYSTEMS REVIEW

Please check all that you have experienced, past or present.

EENT

□Recent visual changes □New loss of taste or smell □Poor vision □Blurry vision □Tunnel vision □Glasses □Contacts
□Cataracts □Glaucoma □Eye strain □Night blindness □Poor night vision □Color blindness □Floaters or spots
□Eye pain □Eye redness □Eye dryness □Eye itchiness □Eyes feel sticky □Bags under eyes □Dark circles under eyes
□Excessive tearing □Earaches □Ear ringing/tinnitus □Ear infections □Ear pressure □Dry ears □Itchy ears
□Excessive wax production □Recent changes in hearing □Poor hearing □Sinus problems □Sinus infections
□Sinus congestion □Stuffy nose □Runny nose □Post nasal drip □Hay fever or allergies □Sneezing attacks
□Nose bleeds □Jaw problems □Clenching teeth □Grinding teeth □Dental surgery □Poor dental health
□Bleeding Gums □Dry mouth □Dry throat □Sore throat □Mouth ulcers □Recurring or frequent sore throat
□Phlegm in throat □Difficulty swallowing □Weak voice □Hoarseness of voice □Other/Not Listed
**Details regarding any of the above:*_____

INFECTIOUS DISEASE AND IMMUNE SYSTEM

□Hepatitis □HIV/AIDS □Herpes virus □Canker sores □Cold sores/oral herpes □Genital warts/genital herpes □HSV
□HPV □Gonorrhea □Syphilis □Measles □Mumps □Rubella □Diphtheria □Influenza □COVID-19 □Pneumonia
□Bronchitis □Common cold □Staph (staphylococcus) infection □Strep infection □Strep throat □E-Coli infection
□C-Diff (clostridioides difficile) □MRSA infection □VRE infection □MDRO's (multidrug-resistant organisms)
□Tetanus □Tuberculosis □Giardiasis □H. Pylori □Meningitis □CMV (cytomegalovirus) □Herpes Zoster/Shingles
□Varicella-zoster/Chickenpox □Epstein-Barr/Mononucleosis □Pertussis/Whooping Cough □Frequent colds or flus
□Frequent upper respiratory issues □Other/not listed *Details regarding any of the above:_____
_____
How many times per year do you experience common cold, illness, or infection of any type?_____
When you get sick, do the symptoms quickly or easily progress to your chest with lung congestion or infection? _____

ORTHO/NEURO

□Headache □Headaches with nausea □Lightheadedness □Dizziness □Vertigo □Concussion □Head injury
□Loss of consciousness □Tremors □Tics □Stuttering or stammering □Slurred speech □Gagging or need to clear throat
□Muscle spasm □Muscle twitching □Muscle cramps □Body aches □Neck pain □Shoulder pain □Neck to shoulder pain
□Upper back pain □Mid back pain □Low back pain □Tailbone pain □Sciatica □Sore knees □Weak knees □Cold knees
□Seizures □Poor memory □Forgetful □Difficulty concentrating or focusing □Foggy mindedness □Disordered thinking
□Difficulty making decisions □Unclear/cloudy thinking □Poor comprehension □Other problems with thinking

□Peculiar tastes □Peculiar smells □Lack of coordination □Clumsiness □Loss of balance □Dropping items □Paralysis
□Muscle weakness □Body feels heavy □Body feels weak □Limbs feel heavy □Limbs feel weak □Areas of numbness
□Muscle pain or discomfort □Joint pain or discomfort □Bone pain or discomfort □Areas of abnormal sensation
□Areas of poor sensation □Areas of absent sensation □Tingling □Neuropathy □Abnormal reflexes
□Facial asymmetry or drooping □Other/not listed *Details regarding any of the above:_____

Hand dominance: □Right □Left □Ambidextrous

Do you have range of motion loss, joint stiffness, or loss of flexibility? □Yes □No *If yes, where?_____
Is the range of motion loss/joint stiffness/loss of flexibility worse at any particular time of day? _____

If you have pain or discomfort, where is it? _____
If you have pain or discomfort, does it get worse with certain types of weather? □Yes □No □Maybe - I'm not sure
**If yes, what type of weather makes (or possibly makes) your pain or discomfort worse?* □Cold or cool weather
□Damp weather or rain □Windy weather □Warm or hot weather □Humid weather □Other/not listed
**If weather affects your pain or discomfort, please give any details:* _____

If you have pain or discomfort, what makes it better? □Warmth or heat □Cold or ice □Acupuncture □Massage □Rest
□Activity, movement, or exercise □Changing my position □Meditation □Yoga □Breathing techniques □Guided imagery
□Music □Social support □Active gratitude practice □Positive psychology □Counseling/psychotherapy □Drugs or alcohol
□Distraction with another activity □Oral medication or topical preparations □Supplements or vitamins □Other/not listed
*Please give any details about what makes the pain or discomfort better:_____

**If you have pain or discomfort, what makes it worse?* □Warmth or heat □Cold or ice □Acupuncture □Massage □Rest
□Activity, movement, exercise □Changing my position □Negative thinking □Anxiety or worry □Depression or sadness
□Drugs or alcohol □Oral medication or topical preparations □Other/not listed **Please give any details about what makes the pain or discomfort worse:*_____

PHYSICAL TRAUMA HISTORY

Have you ever broken any bones or dislocated any joints? □Yes □No *If yes, please describe which bone(s) or joint(s) and how it happened: _____
Have you had any falls that resulted in an injury? □Yes □No *If yes, please describe:_____
_____
Have you had any sports related injuries? □Yes □No *If yes, please describe:_____
_____
Have you ever been involved in a motor vehicle accident that resulted in an injury? □Yes □No *If yes, please describe:
_____
Have you had a head injury that resulted in a concussion? □Yes □No * If yes, please describe: _____
_____
Have you had a head injury that resulted in a loss of consciousness? □Yes □No *If yes, please describe:_____
_____

ANS

□Feeling faint □Fainting □Fevers □Feverish feelings □Hands or feet get hot □Face gets hot □Head or scalp gets hot
□Chest gets hot □Body temperature feels warm or hot □Chills □Chills with shaking □Body temperature feels cool or cold
□I get cold "in the bones" □Hands or feet get cool or cold easily □Hands or feet easily sweat □I tend to sweat easily
□I tend to sweat profusely □Unusual sweating □Hot flashes or feeling hot during day □Hot flashes or feeling hot at night
□Night sweating □Spontaneous day sweating □Difficulty with body temp regulation □Feeling hot to cold and vice versa
□Body temperature feels normal □Other/not listed *Details regarding any of the above:_____

SKIN

□Sensitive skin □Hives □Rashes □Dryness □Oily scalp □Oily skin □Psoriasis □Eczema □Itchiness □Dandruff □Ulcerations □Cysts or tumors □Pimples □Acne □Rosacea □Nail or other fungus □Dry or brittle nails □Dry hair □Dry lips □Edema or swelling □Hair loss □Moles □Recent changes in hair, skin or nails □Other/not listed

*Details regarding any of the above: _____

LUNGS/HEART/THORAX

□Bleed easily □Bruise easily □Fainting □Shortness of breath □Bronchitis □Pneumonia □Emphysema □Asthma □COPD □CHF □Water retention or swelling □Pacemaker □High blood pressure □Low blood pressure □Wheezing □Difficulty breathing □Pain with deep breath □Cough with phlegm □Production of phlegm □Dry cough □Coughing blood □Subcostal tension □Tightness under ribs □Chest pain □Chest discomfort □Chest pressure □Chest tightness □Heart palpitations □Murmur □Irregular heartbeat □Skipped heartbeats □Rapid heartbeat □Pounding heartbeat □Cold hands or feet □Blood clots □Poor circulation □Swelling of hands □Swelling of feet □Swelling of lower extremities □Varicose veins □Peripheral vascular disease □Frequent sighing □Other/not listed *Details regarding any of the above:

_____

Blood pressure typical readings - Please include systolic (top) and diastolic (bottom) numbers: _____

Pulse - Typical readings: _____

GI/GU

□No appetite □Low appetite □High appetite □Normal appetite □Absent thirst □Low thirst □High thirst □Normal thirst □Thirst with no desire to drink □Prefer cold drinks □Prefer warm drinks □Prefer room temp drinks □Nausea □Vomiting □Heartburn □GERD □Reflux □Bad breath □Gassiness □Bloating □Belching □Flatulence □Indigestion □Abdominal pain □Abdominal discomfort □Abdominal cramps □Diarrhea □Constipation □Soft stools □Dry stools □Inflammatory bowel disease □Foul smelling stools □Frequent stools □Bowel movement urgency □Rectal pain □Discomfort/pain with bowel movement □Discomfort/pain after bowel movement □Alternating constipation and diarrhea □Black or clay colored stools □Abnormally colored stools □Thin or ribbon-like stools □Blood in stools □Hemorrhoids □Mucous in stools □Undigested food in stools □Long-term laxative use □Loss of stool or bowel incontinence □Infrequent bowel movements □Bowel movements can skip days □Fatigue after bowel movements □Hernia □Anal fissure □Urgent urination □Frequent urination □Leakage of urine □Loss of urine □Bladder incontinence □Night time urination □Urinary delay □Decreased flow □Discomfort or pain during urination □Cloudy urine □Urine with foul odor □Dark urine □Pale urine □Difficulty starting urination □Difficulty stopping urination □Weak urinary stream □Split stream urination □Pain or discomfort with urination □Burning with urination □Incomplete emptying of bladder □Frequent waking to urinate □Frequent urinary tract infection □Blood in urine □Kidney stones □Bladder stones □Other/not listed *Details regarding any of the above:_____

_____

Average number of bowel movements per day: □0 □0-1 □1-2 □2-3 □3-4 □4+

Average number of bowel movements per week: □0-3 □3-6 □6+

Urinary frequency: □0-1x per day □1-3x per day □3-6x per day □6-8x per day □8-10x per day □10x+ per day

ENERGY

□Feeling hyperactive/wired □Feeling ungrounded □Fatigue □Tired easily □Fatigue upon waking □Fatigue after eating □Sudden drop in the afternoon □Take naps □Other/not listed *Details regarding the above:_____

If you take naps, how often? □Daily □1-2 x per wk □2-3 x per wk □3-4 x per wk □4+ x per wk □1-3 x per month

Do you experience a drop in your energy level during any part of the day? □Yes □No □Sometimes

*If yes, what time? _____

Energy level scale: 0 = Sleeping. 5 = Average; enough to do what you need to do 10 = Hyperactive

Using the scale above, what is your current energy level:_____What is your average day-to-day energy level?_____

If this is different from what your energy level used to be, what was your typical energy level? _____

ADL/IADL

□Independent with all daily living tasks □Use of assistive devices for self care (bathing, dressing, grooming)
□Use of assistive devices for mobility (cane, walker, wheelchair) □Need assistance with self care tasks
□Need assistance with home management tasks □Need assistance with daily living tasks

LIFESTYLE AND SOCIAL HISTORY

Occupation and title, employer, employment status (FT/PT/Retired/Out of work/Self-employed/Homemaker, etc.), or school:

_____

Work days and hours:_____Can you or do you work from home? If yes, what days? _____
Food intolerances: _____
Please list any special diet you have (i.e. low carb, vegan, vegetarian, gluten-free, etc.): _____

_____

Do you restrict your diet in any other way? If yes - with what foods and why? _____

_____

Have you gained weight in the last year? □Yes □No □Not sure *If yes - how much, and do you know why?

_____

Have you lost weight in the last year? □Yes □No □Not sure *If yes - how much, and do you know why?

_____

Do you skip any meals? □Yes □No *If yes - which ones, and why?_____
Please describe your typical daily dietary intake. Include breakfast, lunch, and dinner:_____

_____

_____

Do you snack between meals? □Yes □No □Sometimes *If yes or sometimes, between which meals?

_____

What do you eat for snacks? _____
Do you crave certain foods, or have certain favorite foods? □Yes □No □Sometimes
*If yes or sometimes - what flavors and foods?
□Sweet □Candy □Salty □Crunchy □Spicy □Savory □Chocolate □Ice cream □Peanut butter □Bread □Pasta □Potatoes □Pizza □Hot wings □Bacon □Steak □Ribs □Eggs □Cheese □Pickles □Fruit □Citrus □Other/not listed *Please note which are cravings, which are favorites, and give any details regarding any of the above:

_____

How much water do you drink per day (in ounces)? _____
Intake of other beverages: □Dairy milk □Nut milk □Juices □Sweet tea □Unsweetened tea □Decaf herbal tea □Matcha □Kombucha □Kefir □Non-alcoholic beer □Flavored seltzer water □Plain seltzer water □Tonic water □Club soda □Other/not listed *How much of each of the above per week or day?_____

Do you use any of the following substances? □Coffee □Caffeinated soda □Alcohol □Cigarettes □Chewing tobacco □Vaping nicotine □Vaping other substances □Marijuana □THC □ CBD □Psilocybin (magic) mushrooms □Stimulants □MDMA □Cocaine □Crack □Speed □Methamphetamines □Opioids □Heroin □Methadone □Morphine □Oxycodone □Fentanyl □Other/not listed *Details regarding any of the above:_____

_____

If you drink alcoholic beverages - how much, and of what type, per week or day?_____
If you use any of the other substances listed above - how much per week or day?_____
If you drink caffeinated coffee, tea, or soda - how much per week or day?_____
If you smoke, use tobacco, or vape - how much of each per week or day? _____
Average daily life stress level:
□None □Very low □Low □Low to moderate □Moderate □Moderate to high □High □Off the charts □I'm not sure
My stress is: □Well managed □Fairly managed □Poorly managed □I don't manage it □What stress? I don't have any.
What are your coping strategies? How do you relax and decompress? _____
Have you had experience with stress management, coping strategies, or relaxation techniques? □Yes □No

*If yes, which ones: □Meditation □Mindfulness practice □Guided imagery □Visualization exercises
□Breathing techniques □Yoga □Other/not listed *Details regarding any of the above:_____
If you have had experience with stress management, coping strategies, and relaxation techniques, were they helpful?
□Yes □Somewhat helpful □No
Would you be interested in learning additional stress management, coping strategies, or relaxation techniques?
□Yes □No □Maybe
Birth city, state, and country:_____
Relationship status: □Married □Separated □Divorced □Widowed □Single □Life Partner
Number of children living with you: _____ Number of children living away from home:_____
Number and type of pets living with you:_____
Do you have any hobbies or interests?_____
What would you do with your time if you could do anything you wanted?_____
Do you like to exercise? □Yes □No □Sometimes □Certain types of exercise:_____
Do you have a regular exercise program? □Yes □No *If yes, describe your routine (what do you do, and how often):
_____
Do you consider yourself spiritual or religious? □Yes □No *If yes - what is your belief system and practice?
_____

SLEEP
□Difficulty falling asleep □Waking during night □Light sleeper □Heavy sleeper □Restless sleeper □Vivid dreams
□Waking with physical discomfort □Waking with emotional discomfort □Disturbing dreams □Nightmares
□Sleep walking □Sleep talking □Other/Not listed *Details regarding any of the above:_____
How many hours of sleep per night do you get, on average? _____ Do you feel like you get enough sleep? □Yes □No
Do you feel rested upon waking up? □Yes □No

PSYCHOSOCIAL, EMOTIONAL, AND BEHAVIORAL
□Anger □Irritability □Frustration □Aggressiveness □Easily frustrated □Anxiety or nervousness □Worry □Sadness
□Over thinking □Obsessive thinking □Compulsive behavior □Binge drinking □Binge eating □Compulsive eating
□Depression □Grief □Joy □Thankfulness □Compassion □Fearfulness □Timidity □Shyness □Indecisiveness
□Apathy □Low motivation □Sluggishness □Hyperactivity □Restlessness □Stress □Easily stressed □Pessimist
□Suicidal ideation □History of suicide attempts □Limited support system □Adequate support system □Optimist
□Realist □Introvert □Extrovert □Other/not listed *Details regarding any of the above:_____

Have you had therapy or treatment for stress, emotional, or relationship problems? □Yes □No *If yes - Did it help? Why or why not?_____

How is/was your relationship with your parents? □Excellent □Good □Fair □Poor
If applicable - How is/was your relationship with your sibling(s)? □Excellent □Good □Fair □Poor
If applicable - How is/was your relationship with your life partner or spouse? □Excellent □Good □Fair □Poor
*Details regarding the above: _____

MALE REPRODUCTIVE HEALTH
□N/A – Not my gender □Testicular pain □Testicular swelling □Testicular injury □Testicular inflammation □Prostatitis
□Testicular câncer □Genital pain □Genital itching □Genital warts □Genital lesions □Genital discharge
□Ambiguous genitalia □Sexually transmitted disease □Erectile dysfunction □Premature ejaculation □Change in libido
□Prostate Cancer □Benign prostatic hypertrophy □Enlarged prostate □Seminal fluid leakage □Nocturnal emissions
□Urine leakage □Weak urinary stream □Split stream urination □Low sperm count □Low sperm motility
□Male factor infertility □Vasectomy □Vasectomy reversal □Other/not listed *Details regarding the above: _____
_____

FEMALE REPRODUCTIVE HEALTH

□N/A – Not my gender
Are you pregnant? □Yes □No □Not possible
Do you wish to become pregnant? □Yes □Maybe □No □Not possible *If yes or maybe, when?_____

Last period start date:_____Last PAP/Gynecological exam date:_____Age at first menses: ____

Have you ever had fertility evaluation or treatment? □Yes □No *If yes - When, and please describe:_____
_____

Are you now using, or have you ever used birth control? □Yes □No *If yes – When, what type, and for how long did you use it? _____

# of births:_____ #of pregnancies:_____ # of premature births:_____ # of miscarriages: ____ # of abortions or terminated pregnancies:_____ # of living children, their ages and names (if applicable):_____

Please check below, as applicable:
Perimenopause = 8-10 years before menopause
Menopause = no menstrual period for 12 consecutive months
Postmenopause = no menstrual period for over 12 consecutive months
□Perimenopause □Natural menopause □Surgical menopause □Medical menopause □Postmenopause □N/A

If you are menopausal, what age were you when you began to experience changes in your menses?_____
If you are postmenopausal, what year was your last menstrual period?_____
Or, how old were you when you had your last menstrual period?_____

Average length of menses (eg. 3-5 days):_____Average length of full cycle (eg. 28 days):_____

Is (or was) your period: □Irregular □Painful □Heavy □Medium □Light □Clotted □Bright red □Brown □Dark red □Pale red □Purple □Other/not listed *Details regarding any of the above:_____

Please check any symptoms that you experience or have experienced: □Cramping before period □Cramping during period □Cramping after period □Cramping with ovulation □Mid-cycle spotting □Breast swelling with menses □Breast tenderness with menses □Bloating with menses □Water retention with menses □Low back pain with menses □Joint pain with menses □Nausea with periods □Headache with menses □Mood changes with period □Digestive changes during menses □Food cravings with menses □Other/not listed *Details regarding any of the above:_____
_____

Please check any that apply, that you experience, or have experienced: □Low libido □Abnormal vaginal discharge □Excessive vaginal discharge □Genital pain □Genital itching □Frequent yeast infections □Abnormal PAP smear □Frequent bacterial vaginal infections □Frequent urinary tract infections □Sexually transmitted disease □Hysterectomy □Cervical dysplasia □Uterine cancer □Cervical cancer □Vaginal cáncer □Tubal ligation □Pain with intercourse □Breast lumps □Ovarian cysts □Vaginal dryness □Vulvar varicosities □Infertility □Endometriosis □Uterine fibroids □Cervical polyps □Ambiguous genitalia □PCOS □Other/not listed *Details regarding any of the above:_____
_____

Pregnancy Experience
□Edema/swelling □Nausea □Vomiting □High blood pressure □Gestational diabetes □Headache □Dizziness □Vertigo □Other physiological issues □Other emotional issues □Other/not listed *Details regarding any of the above:
_____

Labor and Childbirth Experience
□Delayed labor □Prolonged labor □VBAC □Natural birth □Home birth □Breech presentation □Cesarean section
□Emergency cesarean section □Bleeding □Excessive blood loss □Other complications □Other/not listed
*Details regarding any of the above:_____

Post Natal Conditions
□Nausea □Vomiting □Headache □Dizziness □Vertigo □Bleeding □Excessive blood loss □Chills □Fever
□Sweating □Post partum depression □Other physiological issues □Other emotional issues □Other complications
□Other/not listed *Details regarding any of the above:_____

THANK YOU!
We sincerely appreciate your assistance in completing a thorough evaluation. Is there anything else we should know?
_____

Please check below, and upload, attach, or include any of the below documents that may be relevant in your care:

□X-Ray □MRI reports □MRA reports □Consultation reports □Operation/procedure report □Office note with diagnosis list
□Office note with medication list □Recent laboratory or blood tests □Recent office notes from other providers (specialists, ND, OT, PT, chiropractic, etc.) □Other/not listed:_____

PRINT NAME OF PATIENT: _____
RELATIONSHIP TO PATIENT (self, guardian, etc.):_____
PRINT NAME OF GUARDIAN (if applicable): _____
DATE:_____
SIGNATURE: _____

Reserved for provider use only below this line
****

Diagnosis: _____
_____
_____

Treatment Plan (Duration/Frequency):_____
_____
_____
_____

Treatment Provided Today:_____
_____
_____
_____

Other:_____

Treatment Goal(s):
□Increase awareness of self care needs □Maximize independence in self-care and health maintenance
□Return to previous level of function □Decrease level of discomfort to allow for return to prior activities
□Decrease level of discomfort to allow for optimal quality of life □_____
Referrals:_____