BODYSCAPES Acupuncture

Men's Fertility Form Date: _____

Please complete this form as thoroughly as possible. All information you provide is pertinent to the proper diagnosis and treatment of your medical condition. All information provided is kept confidential.

General Information

Name (first): _____ (last): _____ Date-of-Birth: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address (please print clearly): _____

Emergency Contact (name): _____ Phone Number: _____

Primary Physician: _____ Phone Number: _____

How did you hear about Bodyscapes? □ Internet □ Doctor Referral □ Ad □ Event □ Word-of-Mouth

Medical History

How was your childhood health? _____

Any past or future surgeries? (include dates) _____

Any significant trauma? (auto accidents, falls, emotional, sexual) _____

Do you have any allergies? Yes No If yes, please list: _____

Have you had any long-term or frequent use of antibiotics? Yes No Describe: _____

Please indicate if you have or have had any of the following conditions:

□ Pneumonia	□ Seizures	□ High blood pressure	□ Heart attack
□ Tuberculosis	□ Multiple sclerosis	□ Low blood pressure	□ Blood transfusion
□ Hepatitis	□ Autoimmune	□ Heart disease	□ Anemia
□ Diabetes	□ Osteoporosis	□ Gout	□ Arthritis
□ Epilepsy	□ Crohn's	□ Cancer	□ STD
□ Kidney stones	□ IBS	□ Measles	□ Mental breakdown
□ Hyper thyroid	□ Colitis	□ Mumps	□ Obesity
□ Hypo thyroid	□ Dementia	□ HIV/Aids	□ Jaundice
□ Premature graying	□ Mental illness	□ Drug reaction	□ Parasites

Sleep

Do you sleep well? □ All the time □ Most of the time □ Some of the time □ Hardly ever

Do you fall asleep easily? Yes No
Do you feel rested when you wake? Yes No
Do you wake during the night? Yes No
Do you fall back to sleep easily? Yes No

Do you have lots of dreams? Yes No
Do you have sleep apnea? Yes No
Do you get night sweats? Yes No
Do you nap during the day? Yes No

Average hours of sleep per night: _____ Energy level (10 being best)? 1 2 3 4 5 6 7 8 9 10

Physical Activity

Do you exercise? Yes No How often? _____ How long? _____
What types of exercise do you do? _____ Do you like to exercise? Yes No
What kind of work do you do? _____
How many hours spent at the computer daily? _____ Hours of TV you watch daily? _____
Check physical activities you enjoy:

□ Walking	□ Camping	□ Weight training	□ Zumba
□ Running	□ Boating	□ Stretching	□ Yoga
□ Swimming	□ Outdoor sports	□ Personal training	□ Tai chi
□ Cycling	□ Hiking	□ Pilates	□ Qi gong
□ Spinning	□ Team sports	□ Dance	□ Martial arts

Is there any medical reason for not being able to exercise? Yes No
If yes, please explain: _____

Mental/Emotional State

Check all that apply to you:

□ Happy	□ Foggy thinking	□ Sadness	□ Irritable
□ Anger	□ Anxiety	□ Fearful	□ Frustrated
□ Depression	□ Worry	□ Panic attacks	□ Memory loss
□ Sluggish thinking	□ Grief	□ Poor concentration	□ Other _____

Are you currently under any unusually high stress? _____ Explain: _____
Do you receive weekly counseling/psychotherapy? _____
Do you regularly do any awareness practices (meditation, prayer, affirmations, etc.) Yes No

Respiratory System

Check all that apply to you:

□ Allergies	□ Sinus headache	□ Dry mouth/throat	□ Asthma
□ Ear ache	□ Frequent colds	□ Tongue sores	□ Bronchitis
□ Tinnitus	□ Cough/wheezing	□ Canker sores	□ Lung congestion
□ Sinus congestion	□ Excessive phlegm	□ Bad breath	□ Enlarged glands
□ Sinus infection	□ Sore throat	□ Shortness of breath	□ Chills/Fever

Cardiovascular System

Check all that apply to you:

□ Chest pain	□ Palpitations	□ Fatigue
□ High blood pressure	□ Shortness of breath	□ Cold hands/feet
□ Low blood pressure	□ Dizziness	□ Poor circulation

Urinary System

What color is your urine?

□ Clear	Check all that apply to you:	
□ Cloudy	□ Profuse urination	□ Difficult urination
□ Yellow	□ Low back pain	□ Discharge
□ Dark yellow	□ Kidney stones	□ Burning
□ Reddish	□ Bladder infections	□ Urgency
□ Scanty urination	□ Frequent PM urination	□ Swollen hands or feet
	□ Lack of bladder control	

Skin/Hair/Nails

Check all that apply to you:

□ Dry
□ Oily
□ Combination
□ Hair loss
□ Acne
□ Eczema
□ Psoriasis
□ Rash
□ Skin ulcer
□ Fungal infection
□ Athlete's foot

Skeletal System

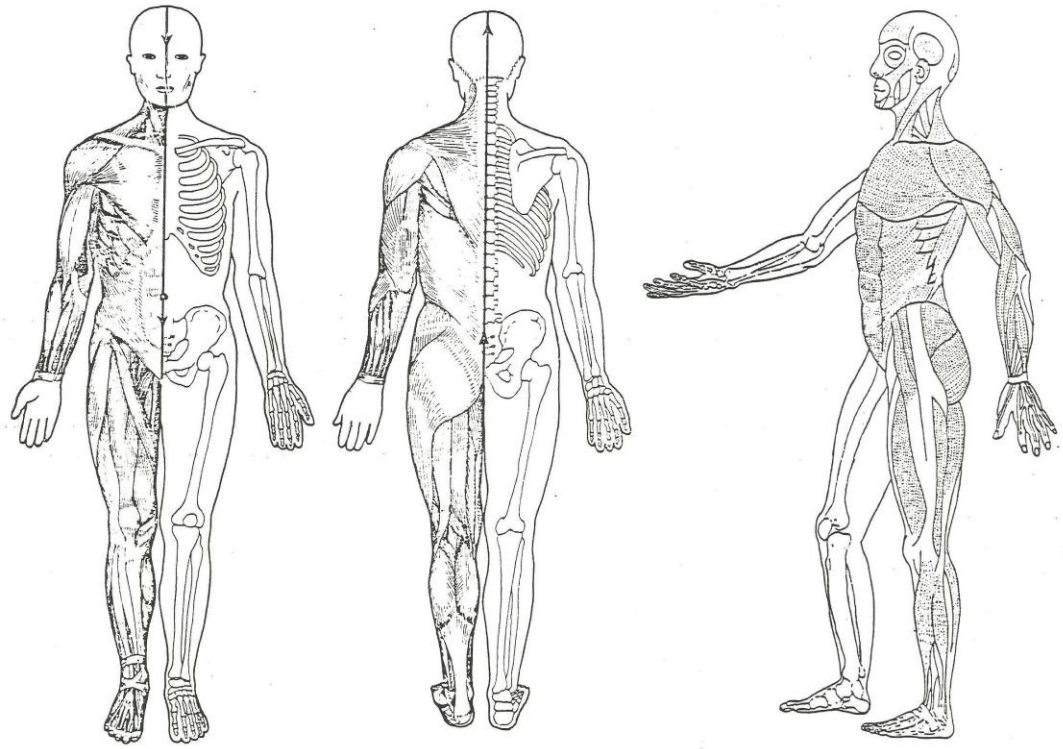
Check all that apply to you:

□ Broken bones
□ Fractures
□ Dislocations
□ Osteoporosis
□ Osteopenia
□ Scoliosis
□ Spinal stenosis
□ Spondylolisthesis
□ Bone spurs
□ Degenerating disc
□ Bulging disc
□ Osteoarthritis
□ Rheumatoid arthritis
□ Bursitis
□ Joint swelling
□ Lots of cavities
□ TMJ dysfunction
□ Teeth grinding

Neuromuscular

Please check all that apply to you and place X's on the anatomy chart where you experience discomfort:

□ Muscular pain
□ Low back pain
□ Sciatica
□ Neck pain
□ Shoulder pain
□ Migraine
□ Tension headache
□ Muscle cramps
□ Muscle twitching
□ Numbness
□ Tingling
□ Neuropathy
□ Fibromyalgia
□ Tendonitis
□ Carpal tunnel
□ Shin splints
□ Plantar fasciitis
□ Other _____



Is your pain:

□ Dull
□ Achy
□ Sharp
□ Cramping
□ Burning
□ Fixed
□ Moves around
□ Throbbing
□ Constant
□ Comes & goes
□ Worse AM
□ Worse PM

Have you used any self-care techniques (cold/heat pack, self massage, biofeedback, etc.)? _____
Have you received any physical therapy or other types of therapy for your pain? _____

Eyes/Ears

Check all that apply to you:

□ Red eyes □ Dry eyes □ Blurry vision □ Tinnitus
□ Itchy eyes □ Floaters □ Ear infection □ Hearing loss
□ Eye pain/strain □ Spots in eyes □ Vertigo □ Meniere's disease

Gastrointestinal System

Check all that apply to you:

□ Constipation □ Blood in stools □ Bloating □ Abdominal pain
□ Diarrhea □ Mucus in stools □ Gas □ Tongue sores
□ Loose stools □ Putrid/smelly □ Acid reflux □ Bad breath
□ Fluctuating stools □ Hemorrhoids □ Nausea □ Bruise easily
□ Colitis □ Ulcers □ IBS □ Crohn's disease

Diet

How is your appetite? _____ How many meals per day do you eat? _____
How often do you have a bowel movement? _____
Are you thirsty? _____ How much water do you drink per day? _____
Do you prefer cold or hot beverages? _____Do you drink caffeine? _____ How many cups per day? _____
List other beverages you drink including juice, rice milk, almond milk, soy milk, tea, etc:
_____
What dairy products do you eat? _____
Are you a vegetarian or vegan? _____List sources of meat/protein: _____
What % of your diet is organic? _____ Do you have any particular cravings? _____
List any food allergies or sensitivities: _____
Do you eat regularly at fast food restaurants? _____ Times per week you eat out? _____
Do you eat a lot of processed food? _____ Do you eat late at night? _____ Do you chew your food well? _____
Do you think you get enough fresh fruits, vegetables, and whole grains daily? _____
Do you drink alcohol? _____How much? _____ Do you smoke cigarettes? _____ How much? _____
Do you take any other recreational drugs? _____
How would you describe your diet? □ Unhealthy □ Fair □ Good □ Fantastic
How would you rate your cooking skills on a scale of 1-10 (10 being best)? 1 2 3 4 5 6 7 8 9 10
Are you ready and willing to make changes in your diet if need be? _____

Body Temperature

Check all that apply to you:

□ Feel cold often □ Feel hot often □ Perspire easily
□ Dislike the cold □ Dislike the heat □ Lack of perspiration
□ Cold hands □ Afternoon flushes □ Heat in soles, hands, and chest
□ Cold feet □ Night sweats

Fertility History

Check all that apply to you:

□ Erectile dysfunction □ Premature ejaculation □ Low sperm count
□ Low libido □ STD □ Poor sperm morphology
□ Testicular pain □ Varicocele □ Poor sperm motility

Have you taken any of the following:

□ Testosterone replacement therapy □ Antifungal medications
□ Long-term anabolic steroid use □ Ulcer medications
□ Cancer medications (chemotherapy)

Have you ever had any surgery of the bladder, prostate or urethra? Yes No If yes, please describe:

_____

Have you previously fathered a child? Yes No How long ago? _____

Do you □ smoke cigarettes □ drink alcohol □ do recreational drugs (please circle)? Never On occasion Frequently

Have you been overexposed to certain environmental elements such as heat, toxins and chemicals? Yes No

Have you ever been diagnosed with Celiac disease? Yes No

Do you do any prolonged bicycle riding? Yes No

Any other issues I should be aware of: _____

Please list medications you are currently taking

_____
_____
_____
_____

Please list herbs/supplements you are taking

_____
_____
_____
_____

Thank you for completing this form.