BODYSCAPES Acupuncture

Women'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: __________ Age:________

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

Reason for seeking treatment:

Primary reason: ____

Secondary reasons: ____

Are you currently going through Assisted Reproductive Therapy (ART)? □ Yes □ No Type of therapy: ___________

Have you gone through any Assisted Reproductive Therapies in the last few years? □ Yes □ No

Please list: ____

Current Fertility

Are you currently under the care of an: □ Endocrinologist □ Reproductive Endocrinologist □ Neither □ Other

How long have you been trying to conceive? ____

Have you received?

□ Fertility lab work-up
□ Hysterosalpingogram (HSG)
□ Ultrasound (sonogram)
□ Antral follicle count (AFC)
□ Clomid challenge test (CCT)
□ Semen analysis

Any abnormal results? (Please list): ____

Have you been diagnosed with any of the following?

□ Anemia
□ Adrenal fatigue
□ Autoimmune disease
□ Blood clotting issues
□ Chlamydial infection
□ Endometriosis
□ Diabetes
□ Grave's disease

□ Hashimoto's disease
□ Hormonal imbalances
□ Hyperthyroidism
□ Hypoglycemia
□ Hypothyroidism
□ Insulin resistance
□ Pelvic adhesions

□ Polycystic ovarian syndrome
□ Pelvic inflammatory disease
□ Pelvic abnormalities
□ Prolactinemia
□ Uterine fibroids
□ Vitamin D deficiency

Male Diagnosis

□ Varicocele
□ Prostate issues
□ Erectile dysfunction
□ Abnormal sperm

Other diagnosis: ____

Menstrual Cycle

Age/onset of menses: ______ Has your menstrual cycle been regular since the onset? □ Yes □ No

Date of last menstrual period: ________ Is your menstrual cycle currently regular? □ Yes □ No

If yes, how long are your cycles? ____________If no, please describe: ____

Please check any of the following that currently (within last year) apply to you

□ Anemia
□ Breast tenderness
□ Bruise easily
□ Clots
□ Chronic vaginal discharge
□ Chronic yeast infections
□ Excessive facial hair
□ Hair loss
□ Heavy flow
□ Hot flashes or night sweats
□ Hormonal migraine
□ Infrequent or no periods
□ Insomnia
□ Irritability
□ Mid-cycle spotting
□ Oily or dry skin
□ Painful periods
□ Premenstrual syndrome
□ Premenstrual spotting
□ Premenstrual acne
□ Premenstrual low back pain
□ Premenstrual diarrhea
□ Scanty flow

Menstrual chart (please complete)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color of menstrual blood: normal (N), bright red (BR), Dark (D), pale (PL), rust (R), brown (BR), purple (P)							
Amount of flow: (Heavy=H, Medium=M, Light=L)							
Clots: large (LG), small (SM), dark (D), purple (P), Red (R)							
Cramps: (Mild (MI), Medium (MED), Severe (S)							
Pain (Indicate type and location - low back, headache, right ovary, etc)							
Bloating (check if yes)							
Nausea (check if yes)							

Do you ovulate on your own? □ Yes □ No On what day of your cycle? ____

Do your breasts get tender at/during ovulation? □ Yes □ No

Have you taken medication to help you ovulate? □ Yes □ No

Date of last Pap smear? ______________ Have you ever had an abnormal Pap smear? □ Yes □ No

Have you had any tubal operation? □ Yes □ No Have you ever had an IUD? □ Yes □ No

Have you ever had a cervical biopsy, operation, cauterization, or conization? □ Yes □ No

How many pregnancies have you had? _______________ How many miscarriages have you had? ______________

How many children do you have? ___________________ How many times has a D&C been performed? ________

How many abortions have you had? _________________

Have you taken oral contraceptives? □ Yes □ No When? _______________________ How long? ____________________

Have you ever taken Depo-Provera? □ Yes □ No When? _______________________ How long? ___________________

Have you taken any medications for gynecological conditions other than contraceptives? □ Yes □ No

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? □ Yes □ No

Have you been exposed to any known environmental toxins or hormones? □ Yes □ No □ Not sure

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: ____

Medications you are currently taking

Medication	Reason
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________

Herbs and supplements you are currently taking:

Herb/Supplement	Reason
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________

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

Have you ever had or currently suffer from any of the following conditions? ___

□ Acne
□ Acid reflux
□ Allergies
□ Anemia
□ Asthma
□ Athlete's foot
□ Autoimmune
□ Blood transfusion
□ Bone spurs
□ Bone fractures
□ Bronchitis
□ Bulging disc
□ Bursitis
□ Cancer
□ Candidiasis
□ Carpal tunnel
□ Colitis
□ COPD
□ Crohn's disease
□ Dementia
□ Degenerating disc
□ Depression
□ Diabetes
□ Drug reaction
□ Eating disorder
□ Eczema
□ Epilepsy
□ Fibromyalgia
□ Frequent colds
□ Fungal infection
□ GERD
□ Gout
□ Heart attack
□ Heart disease
□ Hemorrhoids
□ Hepatitis
□ High blood pressure
□ HIV/Aids
□ Hyper thyroid
□ Hypo thyroid
□ IBS
□ Infertility
□ Jaundice
□ Joint swelling
□ Kidney stones
□ Lots of cavities
□ Low blood pressure
□ Measles
□ Meniere's disease
□ Mental breakdown
□ Mental illness
□ Migraine
□ Multiple sclerosis
□ Mumps
□ Neuropathy
□ Obesity
□ Osteoarthritis
□ Osteopenia
□ Osteoporosis
□ Parasites
□ Plantar fasciitis
□ Pneumonia
□ Premature graying
□ Psoriasis
□ Rash
□ Rheumatoid arthritis
□ Scoliosis
□ Seizures
□ Skin conditions
□ Spinal stenosis
□ Spondylolisthesis
□ STD
□ Teeth grinding
□ Tendonitis
□ Tension headache
□ Tinnitus
□ TMJ dysfunction
□ Tuberculosis
□ Ulcer
□ Vertigo

Please list any other conditions I should be aware of:

____

Chinese Medicine Symptom Evaluation

Please check ALL symptoms you currently have. Be as specific as possible and don't skip any sections. This section is important in evaluating your health from a Chinese Medicine perspective.

Qi Deficiency/Stagnation

□ Fatigue
□ General weakness
□ Low voice
□ Shortness of breath
□ Spontaneous sweating
□ Shallow breathing
□ Laziness to speak
□ Local pain
□ Abdominal distention
□ Feeling of oppression
□ Distending pain
□ Painful swollen breasts
□ Rectal pressure

Counterflow Qi

□ Cough □ Nausea □ Vomit □ Hiccough □ Dizziness

Blood Deficiency/Stagnation/Heat

□ Pale complexion
□ Lusterless complexion
□ Pale lips
□ Dry skin
□ Dry, brittle nails
□ Lifeless hair
□ Hair loss
□ Dizziness
□ Blurry vision
□ Palpitations
□ Insomnia
□ Numbness in extremities
□ Stiffness
□ Dark facial complexion
□ Painful, hard swellings
□ Swollen glands
□ Stabbing pain in fixed location
□ Bruise easily
□ Excess menstrual bleeding
□ Frequent nose bleeds
□ Blood in stools
□ Blood in urine

Lungs

□ Grief
□ Sadness
□ Weak breathing
□ Shortness of breath on exertion
□ Weak cough
□ Thin watery sputum
□ Weak voice
□ Spontaneous sweating
□ Daytime sweating
□ Aversion to Cold
□ Weakened immunity
□ Frequent colds
□ Ear ache
□ Dry cough
□ Cough with sticky sputum
□ Difficult to expectorate
□ Dry mouth and throat
□ Hoarse voice
□ Low grade fever
□ Night sweats
□ Heat in palms, soles and chest
□ Blood tinged sputum
□ Insomnia
□ Thirst
□ Fever
□ Occipital headache
□ Whole head headache
□ Body aches
□ Sneezing
□ Stuffy nose
□ Runny nose with thin clear mucus
□ Itching throat
□ Profuse white phlegm that is easily expectorated
□ Chronic cough
□ Acute attacks
□ Stuffiness in the chest
□ Symptoms worse lying down
□ Yellow or green mucus
□ Foul smelling mucus
□ Sinus infection
□ Asthma
□ Cough with frothy white and watery sputum
□ Chills
□ Vomiting of frothy sputum

Large Intestine

□ Abdominal pain
□ Diarrhea
□ Mucus and blood in the stool
□ Foul stool, burning anus
□ Scanty and dark urine
□ Fever and sweating
□ Thirst without a desire to drink
□ Heavy sensation in the body and limbs
□ Stuffiness in the chest and epigastrium
□ Constipation with dry stools
□ Burning sensation in mouth
□ Burning sensation in anus
□ Scanty and dark urine
□ Dry stools that are hard to pass
□ Dry mouth and throat
□ Loose stools
□ Dull abdominal pain
□ Borborygmus (stomach rumbling)
□ Pale urine
□ Cold Limbs

Spleen

□ Worry
□ Sluggish or foggy thinking
□ Poor Appetite
□ Fatigue
□ Weakness of limbs
□ Loose stools
□ Nausea
□ Full sensation in chest & belly
□ Heavy feeling in head & limbs
□ Abdominal distention after eating
□ Undigested food in stools
□ Weakness of the four limbs
□ Chilliness - cold limbs
□ Edema
□ Uterine prolapse
□ Heavy sensation in abdomen
□ Hemorrhoids
□ Varicose veins
□ Blood in stool/urine
□ Excess menstrual bleeding
□ Cold feeling in belly improved by warmth
□ No thirst
□ Thirst without desire to drink
□ Vomiting
□ Abdominal pain
□ Loose, foul-smelling stools
□ Burning sensation in anus
□ Scanty, dark-colored urine
□ Low-grade fever
□ Headache

Stomach

- □ Abdominal discomfort
- □ Mild abdominal pain
- □ Lack of appetite
- □ Lack of taste
- □ Loose stools
- □ Fatigue esp. in the morning
- □ Weak limbs
- □ Prefer warm drinks & foods
- □ Vomiting of clear fluid
- □ Lack of thirst
- □ Cold limbs
- □ General fatigue
- □ Severe abdominal pain with vomiting
- □ Feeling of fullness after eating
- □ Fever or feeling warm in PM
- □ Dry mouth esp. in afternoon
- □ Constipation with dry stools
- □ Burning sensation in stomach
- □ Vomit soon after eating
- □ Sour regurgitation
- □ Bad breath
- □ Strong thirst for cold drinks
- □ Constant hunger
- □ Gum swelling, pain & bleeding
- □ Belching
- □ Hiccough
- □ Insomnia
- □ Stabbing pain in epigastrium
- □ Pain after eating
- □ Vomiting of dark blood
- □ Blood in the stools

Heart

- □ Over excitement
- □ Palpitations
- □ Panic attacks
- □ Dizziness
- □ Pale complexion
- □ Lassitude of spirit
- □ Dizziness
- □ Palpitation
- □ Panic attacks
- □ Shortness of breath
- □ Spontaneous sweating
- □ Oppression in chest
- □ Chest pain
- □ Cold extremities
- □ Feelings of cold
- □ Poor memory
- □ Mental restlessness
- □ Anxiety
- □ Easily startled
- □ Insomnia
- □ Profuse dreaming
- □ Night sweats
- □ Low grade fever
- □ Heat in palms, soles, and chest
- □ Ulcers of mouth or tongue
- □ Blood in urine

Small Intestine

- □ Abdominal pain
- □ Tongue ulcers
- □ Scanty, dark, painful, or bloody urination
- □ Insomnia
- □ Mental restlessness
- □ Throat pain
- □ Thirst
- □ Sudden hearing loss
- □ Twisting pain in the lower abdomen that may radiate to the lower back
- □ Abdominal distention
- □ Pain is worse with pressure
- □ Borborygmus (stomach rumbling)
- □ Flatulence that relieves pain
- □ Testicular pain
- □ Violent abdominal pain that is worse with pressure
- □ Constipation
- □ Vomiting
- □ Abdominal pain relieved by warmth and pressure
- □ Diarrhea
- □ Pale and copious urination
- □ Desire for warm liquids

Liver

- □ Anger
- □ Depression
- □ Anxiety
- □ Frustrated
- □ Poor concentration
- □ Distention and pain along the sides of the abdomen
- □ Frequent sighing
- □ Sensation of a lump in the throat with trouble swallowing
- □ Alternating Constipation and diarrhea
- □ Irregular elimination
- □ Scanty menstruation and/or amenorrhea
- □ Hypertension
- □ Numbness of the limbs
- □ Muscular weakness
- □ Muscle spasms
- □ Muscle cramps
- □ Abdominal distention
- □ Acid reflux
- □ Irregular menstruation
- □ Painful menstruation
- □ Premenstrual breast tenderness
- □ PMS
- □ Irregular periods
- □ Dark and clotted menstrual blood
- □ Fixed and stabbing abdominal pain
- □ Vomiting of blood
- □ Red face and eyes
- □ Irritability
- □ Tinnitus or deafness
- □ Pale, brittle nails
- □ Stress
- □ Pain in the scrotum/testes
- □ Straining of testes or contraction of scrotum
- □ Jaundice
- □ Nausea and vomiting
- □ Temporal headache
- □ Migraine
- □ Dizziness
- □ Thirst
- □ Bitter taste in the mouth
- □ Constipation with dry stools
- □ Insomnia with dream disturbed sleep
- □ Dark yellow urine
- □ Blurred vision or floaters
- □ Loss of appetite
- □ Vaginal discharge and/or vaginal itching

Gallbladder

- □ Difficult making a decision
- □ Pain and distention along sides of abdomen
- □ Nausea
- □ Vomiting
- □ Inability to digest fats
- □ Yellow complexion
- □ Bile backed up
- □ Scanty, dark yellow urine
- □ Fever
- □ Thirst without desire to drink
- □ Bitter taste
- □ Dizziness
- □ Blurred vision
- □ Nervousness
- □ Timidity
- □ Propensity to being easily startled
- □ Lack of courage and initiative
- □ Sighing

Kidney

- □ Fearful
- □ Slow mental and physical development as a child
- □ Poor skeletal development and brittle bones
- □ Soreness and weakness in the lumbar area and knees
- □ Premature graying and hair loss
- □ Dental and teeth problems
- □ Mental retardation
- □ Poor memory
- □ Premature aging
- □ Premature senility
- □ Dizziness
- □ Deafness and/or tinnitus
- □ Low sex drive
- □ Infertility
- □ Chills and aversion to cold
- □ Cold limbs
- □ Swollen hands and feet
- □ Apathy and/or lethargy
- □ Soreness and cold in the lumbar region
- □ Weakness and cold of knees
- □ Impotence or frigidity
- □ Sterility
- □ Copious clear urine
- □ Frequent urination or incontinence
- □ Reduced urine and edema
- □ Loose teeth
- □ Deafness
- □ Loose stool, especially early AM
- □ Asthma or shortness of breath on exertion
- □ Hot palms and/or soles
- □ Red cheek bones
- □ Night sweats
- □ Afternoon fever
- □ Constipation
- □ Dark urine
- □ Thirst
- □ Premature ejaculation
- □ Nocturnal emission (especially with dreams)

Bladder

- □ Frequent or urgent urination and pain or burning during urination
- □ Difficult urination, dark yellow, or cloudy urination
- □ Gravel or Stones in the urine
- □ Fever
- □ Thirst
- □ Frequent and urgent urination, or difficult urination
- □ Heavy sensation in the lower abdominal region and urethra
- □ Pale cloudy urine
- □ Frequent, pale, and copious Urination
- □ Incontinence
- □ Lower back pain

Stress

How would you rate your overall stress level:

□ **Acute** (occurs for short periods of time causing anger, irritability, anxiety, periods of depression, headache, pain, stomach upset, dizziness, heart palpitations, shortness of breath, hypertension and bowel disorders)

□ **Episodic** (will last longer than acute stress causing periods of intermitted depression, anxiety disorders, emotional distress, ceaseless worrying, and persistent physical symptoms similar to those found in acute stress. Symptoms often associated with Type A personality)

□ **Chronic** (brought on by long-term exposure to stressors that cause more serious and chronic health issues such as chronic fatigue, clinical depression, sleep disorders, high blood pressure, auto-immune disorders, etc)

□ **Mild** (Symptoms are mild and dissipate quickly. No long term effects)

Do you receive weekly counseling/psychotherapy? ____

Do you regularly do any awareness practices (meditation, yoga, tai chi, prayer, affirmations, etc.) Yes No

What are the primary causes of stress in your life? ____

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

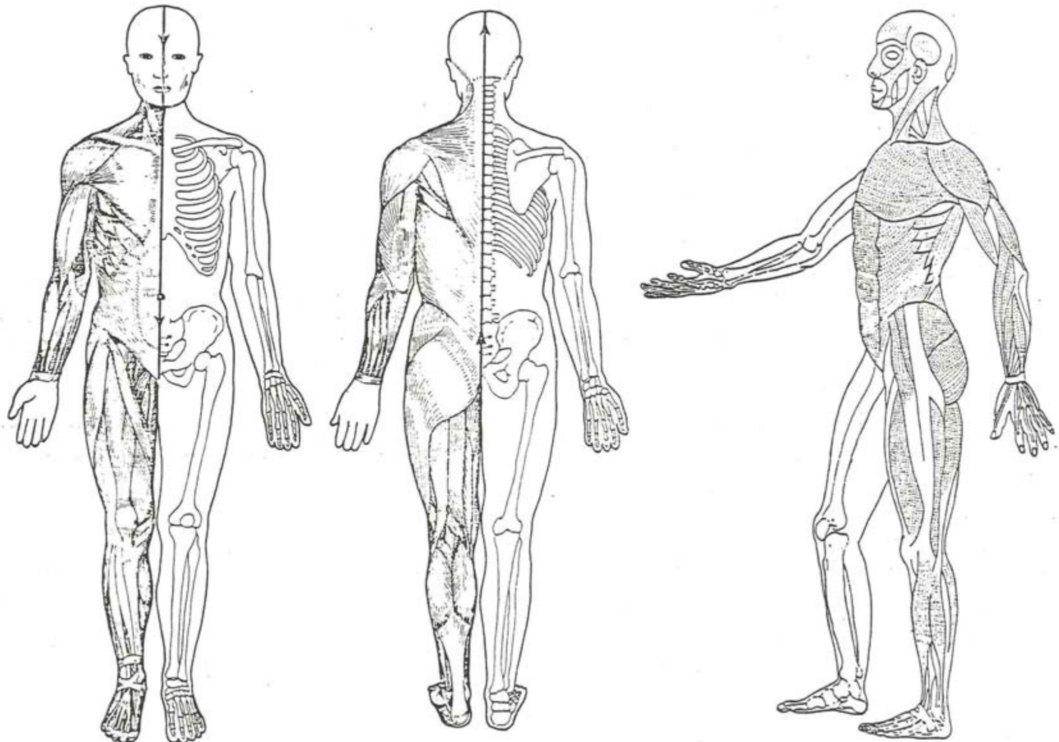
Do you have lots of dreams? Yes No
Do you have sleep apnea? Yes No
Do you get night sweats? Yes No
Do you nap during the day? Yes No

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

Neuromuscular Pain

Please circle the areas of pain or discomfort.

Describe your pain:
□ Dull
□ Achy
□ Sharp
□ Cramping
□ Burning
□ Numbness
□ Fixed
□ Refers
□ Stiffness
□ Swelling
□ Moves around
□ Throbbing
□ Constant
□ Comes & goes
□ Worse AM
□ Worse PM
□ Worse in cold weather
□ Worse in hot weather



Does heat make it feel better? Yes No Does cold make it feel better? Yes No

Have you used any self-care techniques (cold/heat pack, self massage, biofeedback, etc.)? Yes No

Have you received any physical therapy or other types of therapy for your pain? Yes No

Please list:____

Do you take any prescription drugs or over-the-counter drugs for your pain? Yes No

Specify: ____

Body Temperature

Check all that apply to you:

□ Feel cold often
□ Dislike the cold
□ Cold hands
□ Cold Feet

□ Feel hot often
□ Dislike the heat
□ Afternoon flushes
□ Night sweats

□ Perspire easily
□ Lack of perspiration
□ Heat in soles, hands, and chest

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? ____ Hours per week: __________________

How many hours spent at the computer daily? _____________________ Hours of TV you watch daily: _______________

Are you more than 20% over your ideal body weight? □ Yes □ No

Are you more than 20% below your ideal body weight? □ Yes □ No

Check physical activities you enjoy:

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

Are there any reasons and/or conditions that prevent you from exercising regularly? □ Yes □ No

Specify: ____

Diet

How is your appetite? _______________________________ How many meals per day do you eat? _________________

How often do you have a bowel movement? _________ Are you thirsty? _________ Daily water intake: _____________

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? ____

Thank you for completing this form. All information will be kept confidential.