Welcome to Acupuncture Northwest & Associates

Please email to info@acupuncturenorthwest.com OR fax to
Seattle (206)332-1801 **Tacoma** (253) 627-1360

Please note that all information is strictly confidential.

First Name: Today's Date:

Last Name:

Date of Birth: Age:

Single Married Life Partner Divorced Widowed

Address: City/State/Zip:

Home Phone: Work Phone:

Email Address: Cell Phone:

May we correspond with you (invoices, questions, etc.) via email? Yes No

If not, how shall we correspond with you?

Occupation: Name of Company:

In Case of Emergency Contact:

Relationship & Phone:

Family Physician: Phone:

How did you hear about us?

Insurance Information: If Acupuncture Northwest & Associates will be billing your insurance, please fill out the following:

Insurance Name and Phone Number: _____

Name of Guarantor (Primary Plan Holder): _____

Guarantor's Date of Birth: _____

ID Number:_____ Group Number: _____

Men's Fertility Worksheet

This worksheet is to be filled out by men coming to Acupuncture Northwest for fertility issues.

Name of Patient: _____ Sex: M F

Name of Partner: _____ Sex: M F

How long have you been trying to get pregnant? _____

Do you have a diagnosis of infertility? Yes No

When was that diagnosis given? _____

What is that diagnosis?

Male factor? _____

Female factor? _____

What fertility treatments have you tried, when and what was the outcome?

What	When	Where/By Whom

How would you define your sexual energy? Below Normal Normal High

	YES	NO
Do you have any undescended testes?	☐	☐
Have you ever been diagnosed with a varicocele?	☐	☐
Have you had any urologic surgeries?	☐	☐
Have you experienced difficulty maintaining erection?	☐	☐
Have you experienced difficulty ejaculating?	☐	☐
Have you had exposure to any known environmental toxins or hormones?	☐	☐
Have you experienced any unusual penile discharge?	☐	☐
Do you regularly experience nocturnal emission?	☐	☐
Have you had a fertility workup?	☐	☐

If yes, what was your sperm count? Below Normal Normal Number _____

What was the sperm motility? Below Normal Normal Number _____

What was the sperm morphology? Below Normal Normal Number _____

What is your plan from here _____

Please list any other health issues that you would like addressed

1. _____
2. _____
3. _____

How, when and where did these conditions begin?

_____

What types of treatments have you tried, if any?

_____

How does this condition impair your daily activities?

_____

What makes it better or worse?

_____

Height: _____

Weight: _____

Your Medical History:

Surgeries, Major Illnesses, Hospitalizations, Falls and Major Accidents (incl. Dates):

_____

Any falls/injuries to sacrum/head/tailbone (describe):

_____

Any birth trauma that you know of:

_____

Family History:

Health and major emotional states as a child:

_____

List any major health issues in your family (going back to grandparents)

_____

Family History of Substance: Abuse Suicide Other Trauma

History of Abuse: circle if applicable: physical emotional sexual other

Please list any **medications/vitamins/supplements** you are currently taking:

Medications	Reason	When & For how long

Herb/Medication **allergies** and reaction (if any):

_____

Do you have, or have you ever had any of the following illnesses?

AIDS	Allergies	Arthritis	Asthma
Cancer	Chronic Fatigue	Diabetes	Gall Stones
Heart Disease	Hepatitis	High Blood Pressure	Herpes
HIV+	Kidney Stones	Mental Illness	Mononucleosis
Osteoporosis	Parasites	Rheumatic Fever	Seizures
Stroke	Thyroid Problems	Ulcers	Venereal Disease

Other _____

Lifestyle:

Are you following any special diet or food philosophy?

_____

Typical

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks:_____

Worst food in your diet? _____

What foods do you crave?_____

Water intake per day? _____ Soda?____ Juice?_____ Artificial Sweeteners? _____

Caffeine(what form & how much)_____

Do you use

Tobacco? Yes No How much?_____

Alcohol? Yes No How much?_____

Work: Do you enjoy your work? Yes No Hours per week working:_____

Exercise: Do you Exercise? Yes No Number of times/ week:_____

Type of exercise:_____

Sleep:

Do you have trouble falling asleep? Yes No

Time to bed:_____ Time to rise: _____

How many average hours of sleep do you get per night? _____

Are you rested in the morning? Yes No
Do you wake in the night? Yes No

How is your home environment?

_____

Describe any stressors occurring at this time:

_____

What are hobbies/activities that provide you with a sense of pleasure and accomplishment?

_____

What is your opinion of yourself?

_____

What is the most negative emotion you experience?_____

When and Where?_____

Urination: Please check any of the following symptoms you are currently experiencing:

Burning Urgent Retention Scanty Profuse Dribbling
Greater than 1x a night

Bowel Movements: Frequency: _____ Feels complete? Yes No
Painful? Yes No

Consistency(check): Well-formed Hard Loose Alternates

Undigested food Blood Mucus Sink Float

_____

Body Systems Review:

0 = never 1 = rarely 2 = occasionally 3 = frequently 4 = always

0	1	2	3	4	low appetite	0	1	2	3	4	ravenous appetite
0	1	2	3	4	loose stools	0	1	2	3	4	heartburn/acid reflux
0	1	2	3	4	mouth sores	0	1	2	3	4	fatigue after eating
0	1	2	3	4	abdominal gas/bloating after food	0	1	2	3	4	bruise easily
0	1	2	3	4	gums (bleeding/swollen)	0	1	2	3	4	thirst
0	1	2	3	4	organ prolapsed (diagnosed)	0	1	2	3	4	belching or vomiting
0	1	2	3	4	spontaneous sweat	0	1	2	3	4	fatigue
0	1	2	3	4	allergies	0	1	2	3	4	catch colds easily
0	1	2	3	4	asthma	0	1	2	3	4	shortness of breath
0	1	2	3	4	general weakness	0	1	2	3	4	cough
0	1	2	3	4	dry nose/mouth/skin/throat	0	1	2	3	4	nasal discharge
0	1	2	3	4	feel worse after exercise	0	1	2	3	4	sinus congestion
0	1	2	3	4	sore, cold or weak knees	0	1	2	3	4	feel cold (in core)
0	1	2	3	4	low back pain	0	1	2	3	4	cold hands &/or feet
0	1	2	3	4	frequent urination	0	1	2	3	4	urinary incontinence
0	1	2	3	4	early morning diarrhea	0	1	2	3	4	hearing loss
yes		no			impaired memory	0	1	2	3	4	edema
yes		no			hair loss						
0	1	2	3	4	muscle spasms/twitches	0	1	2	3	4	irritable
0	1	2	3	4	feel better after exercise	0	1	2	3	4	numb extremities
0	1	2	3	4	tight feeling in chest	0	1	2	3	4	dry eyes
0	1	2	3	4	alternating diarrhea/constipation	0	1	2	3	4	ear ringing
0	1	2	3	4	symptoms worse with stress	0	1	2	3	4	anger easily
0	1	2	3	4	neck/shoulder tension	0	1	2	3	4	red eyes

0	1	2	3	4	feel heart beating	0	1	2	3	4 chest pain
0	1	2	3	4	insomnia	0	1	2	3	4 disturbing dreams
0	1	2	3	4	sores on tip of tongue	0	1	2	3	4 headaches
0	1	2	3	4	anxiety	0	1	2	3	4 restlessness
0	1	2	3	4	chest pain traveling to shoulder					

high normal low overall body temperature
high normal low overall energy level

0	1	2	3	4	see floaters in eyes	0	1	2	3	4 foggy thinking
0	1	2	3	4	heat in palms or soles	0	1	2	3	4 dizzy upon standing
0	1	2	3	4	feeling of heaviness	0	1	2	3	4 nausea
0	1	2	3	4	afternoon fever	0	1	2	3	4 night sweats
0	1	2	3	4	enlarged lymph nodes	0	1	2	3	4 cloudy urine
0	1	2	3	4	face flushes					

Is there anything else that we should know to best understand and help you?

Thank you for taking the time to fill out this form thoroughly. It will help us serve you better.

Signature: _____ Date: _____