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Men's Health Information

Note: This information is confidential and will not be released without your consent.

Today's Date ____________________

Name ____ Date of Birth ____________________

Address ____

City/State/Zip ____

Phone: Home __________________ Work __________________ Cell ___________________

Email Address ____

Spouse or Partner's Name ____

EMERGENCY CONTACT ____

Phone __________________________________ Relationship to You ____________________

Referred by (if applicable) ____

TODAY'S VISIT

Reason for today's visit____

____

Outcome you hope to achieve through acupuncture ___________________________________

____

Have you had acupuncture before? _____ Reason? ______________________________________

Are you seeing any other alternative or complement practitioners at this time? ______________

If so, when? ____

Have you seen a _____ physician _____ physical therapist _____ chiropractor for this problem?

Other therapies you have tried for this problem _______________________________________

MEDICAL HISTORY

Personal Physician ______________________________ Date of last visit _________________

List all medications and supplements you are taking. **Include vitamins and herbs.**

____

____

____

List all surgeries you have had.

____ Year_____________

____ Year_____________

____ Year_____________

Other hospitalizations or serious injuries ____

Do you have a pacemaker or any other metal in your body?_____________________________

Do you have any artificial joints? _____ Where? ____________________________________

ABOUT YOU

Occupation ____

Hobbies ____

Name/ages of children ____

Name/type of pets ____

WORDS THAT BEST DESCRIBE YOU (check all that apply)

ENERGY AND EMOTION:

___ Normal ___ Low energy ___ High energy

___ Hyperactive at times ___ Often depressed ___ Sometimes depressed

___ Worry a lot ___ Have panic attacks ___ Sleep well

___ Wake up at night ___ Difficulty falling asleep ___ Vivid dreams

THIRST:

___ Normal ___ Often thirsty ___ Thirsty, but don’t drink

BODY WEIGHT:

___ Normal Would like to: _____ lose _____ gain weight

TEMPERATURE:

___ Feel cold easily	___ Feel hot or hot flashes	___ Have cold hands and feet
___ Night sweats	___ Sweat easily	___ Do not sweat when hot

APPETITE:

___ Normal	___ Abnormal	___ Often hungry
___ Poor appetite	___ Hungry, but no desire to eat	
___ Gas after meals	___ Frequent nausea	___ Bloating after meals
___ Stomach pain after meals		

ELIMINATION:

How many bowel movements per day: ____ 0-1 ____ 2-3 ____ 4 or more

___ Chronic or frequent constipation	___ Chronic or frequent diarrhea
___ Blood or mucus in stools	___ Alternating diarrhea and constipation
___ Blood in urine	___ Painful urination

___ Other concerns:____

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING? (check all that apply)

___ High blood pressure	___ Heart attack	___ Other heart problem
___ Stroke	___ Asthma	___ High cholesterol
___ Epilepsy	___ Diabetes	___ Colitis or Crohn's Disease
___ Irritable bowel	___ Diverticulosis	___ Kidney disease
___ Migraine headaches	___ Alcoholism	___ Drug addiction
___ Anemia	___ Stomach ulcers	___ Cancer
___ Obesity	___ Allergies	___ Arthritis
___ Bleeding tendencies	___ History of fainting	___ Vertigo
___ Eating disorder	___ Severe depression	___ Panic attacks
___ Severe anxiety	___ Mild Depression	___ Obsessive Compulsive Disorder
___ Bipolar Disorder	___ Hyperthyroid	___ Hypothyroid
___ Osteoporosis	___ Acid Reflux	___ Restless Leg Syndrome
___ Prostate problems		

List any other conditions that you have that were not listed here___________________________

____

Which of the above conditions "runs" in your family?______________________________________

____

On average, how many beverages of beer, wine or liquor do you drink a week? ______________

On average, how many cigarettes, cigars or pipes do you smoke per week? ________________

Do you chew tobacco?__________________ Do you smoke marijuana? ____________________

On average, how many hours a night do you sleep? _____________________________________

Describe your diet (use the back of this sheet if necessary) _______________________________

____

____

____

____

____

____

____

Do you exercise regularly?___________ If so, please describe what exercises and how often.

____

____

____

What do you do for stress relief? ____

____

____

Do you practice any form of meditation? ____

____

____

FERTILITY

Date of Sperm Analysis ____________________

Results: Count __________ Motility __________ Morphology __________

Did you have a DNA fractionation test done? ______ Results: _____________________________

Do you have a varicocele (varicose vein in the testicles)?________________________________

If yes, did you have it repaired? __________

KYn

Do you have lower back weakness, soreness, or pain or knee problems?	YES	NO
Do you have ringing in your ears?	YES	NO
Do you get dizzy frequently?	YES	NO
Is your hair prematurely gray?	YES	NO
Do you have dark circles around or under your eyes?	YES	NO
Do you have night sweats?	YES	NO
Are you prone to hot flashes?	YES	NO
Would you describe yourself as being afraid a lot?	YES	NO

KYg

Is your low back sore or weak?	YES	NO
Are your feet cold, especially at night?	YES	NO
Are you typically colder than those around you?	YES	NO
Is your libido low?	YES	NO
Are you often fearful?	YES	NO
Do you wake up during the night/early morning because you have to urinate?	YES	NO
Do you urinate frequently, and is the urine diluted or profuse?	YES	NO
Do you have early morning loose or urgent stools?	YES	NO

SP

Are you often fatigued?	YES | NO
Do you have poor appetite?	YES | NO
Is your energy low after a meal?	YES | NO
Do you feel boated after a meal?	YES | NO
Do you crave sweets?	YES | NO
Do you have loose stools, abdominal pain, or digestive problems?	YES | NO
Are your hands and feet cold?	YES | NO
Do you wear socks to bed?	YES | NO
Are you prone to feeling heavy or sluggish?	YES | NO
Are you prone to feeling heaviness or grogginess in your head?	YES | NO
Do you bruise easily?	YES | NO
Do you think you have poor circulation?	YES | NO
Do you have varicose veins?	YES | NO
Are you lacking strength in your arms and legs?	YES | NO
Do you exercise infrequently?	YES | NO
Do you worry often?	YES | NO
Have you been diagnosed with low blood pressure?	YES | NO
Do you sweat a lot with out exerting yourself?	YES | NO
Are you dizzy/lightheaded/have visual changes when standing up quickly?	YES | NO
Are you often sick?	YES | NO
Do you have allergies?	YES | NO
Have you been diagnosed with hypothyroid?	YES | NO
Have you been diagnosed with anemia?	YES | NO

BDf

Do you have dry, flaky skin?	YES	NO
Are you prone to getting chapped lips?	YES	NO
Are your fingernails or toenails brittle?	YES	NO
Do you have thinning hair?	YES	NO
Is your hair brittle or dry?	YES	NO
Do you have diminished nighttime vision?	YES	NO

BSt

Do you have varicose or spider veins?	YES	NO
Do you have red hemangiomas (cherry-red spots) on your skin?	YES	NO
Do you have chronic hemorrhoids?	YES	NO
Have you ever had a blood clot?	YES	NO

LvQiXt

Are you prone to emotional depression?	YES	NO
Are you prone to anger and/or rage?	YES	NO
Do you experience “floaters” in your eyes?	YES	NO
Does your face “flush” often?	YES	NO
Do you have difficulty falling asleep at night?	YES	NO
Do you have heartburn?	YES	NO
Do you wake up with a bitter taste in your mouth?	YES	NO

HtDef

Do you wake up early in the morning and have difficulty falling back asleep?	YES	NO
Do you have heart palpations, especially when anxious?	YES	NO
Do you have nightmares?	YES	NO
Do you seem low in spirit or lacking in vitality?	YES	NO
Are you prone to agitation or extreme restlessness?	YES	NO
Do you fidget?	YES	NO
Do you sweat excessively, especially on your chest?	YES	NO

XHT

Is your pulse rate rapid?	YES | NO
Are your mouth and throat usually dry?	YES | NO
Are you thirsty for cold drinks most of the time?	YES | NO
Do you often feel warmer than those around you?	YES | NO
Do you ever wake up sweating?	YES | NO
Do you have hot flashes?	YES | NO

D

Do you feel tired and sluggish after a meal?	YES | NO
Do you have acne?	YES | NO
Do your joints ache, especially with movement?	YES | NO
Are you overweight?	YES | NO

Do you ride a bicycle or stationary bike? ____ If so, hours/week/month? ____________________

Do you smoke marijuana? ____ If so, how frequently? ____________________________________

Do you spend time a hot tub? ____ If so, how frequently? ________________________________

Where do you carry your cell phone? ___ Front Pants Pocket ___ Belt Clip

Do you eat fast food more than once a week? ____