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Natural Fertility Program

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PERSONAL INFORMATION

(Male intake form)

❒ Mr. Name: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Email: _____

Date of Birth: / / Place of Birth: _____

Any known complications at birth: _____

Occupation: _____

Occupational Stress: ❒ chemical ❒ physical ❒ psychological Other: _____

How many hours/week do you work? Are you satisfied with your job? ❒ Yes ❒ No

Marital Status: ❒ single ❒ married ❒ divorced ❒ widowed ❒ mutually committed

Have you ever had acupuncture? ❒ Yes ❒ No, when?

For what condition?

Was it a good experience? ❒ Yes ❒ No

How were you referred to us?

Can we contact him/her to thank them for the referral? ❒ Yes ❒ No

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MEDICAL HISTORY

What are your reasons/concerns for seeking treatment?

1.-

2.-

3.-

4.-

5.-

When did your health concerns begin?

Your condition is improved by

Your condition is aggravated by

Are you currently under the care of a physician? ❑ Yes ❑ No

For what condition(s)?

Physician's Name: Address:

City: State: Zip:

Phone: Date of last medical doctor visit: / /

What was the reason for your visit to your medical doctor?

Was there a diagnosis offered?

What other methods of therapy (conventional and alternative) have you used for this condition?

Therapy Therapist name Date / /

Response

Therapy Therapist name Date / /

Response

Therapy Therapist name Date / /

Response

Family Medical History (please check all that apply to PARENTS/SIBLINGS):

- ❑ Diabetes Who? _____
- ❑ Cancer Who? _____
- ❑ Heart Disease Who? _____
- ❑ Stroke Who? _____
- ❑ High Blood Pressure Who? _____
- ❑ Seizures Who? _____
- ❑ Asthma Who? _____
- ❑ Allergies Who? _____
- ❑ Other _____

Personal Significant illnesses (please check all that apply TO YOU):

- ❑ Allergies To: _____
- ❑ Cancer
- ❑ Diabetes: ❑Type I (insulin usage) ❑Type II
- ❑ Hepatitis: ❑ A ❑ B ❑ C
- ❑ Heart Disease
- ❑ Stroke
- ❑ Seizures
- ❑ HIV / AIDS
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Multiple sclerosis
- ❑ Thyroid
- ❑ Asthma
- ❑ Stomach Ulcers
- ❑ Obesity
- ❑ Depression
- ❑ Shingles
- ❑ Chronic Fatigue
- ❑ Rheumatic Fever
- ❑ High Blood Pressure
- ❑ STD's
- ❑ Other _____

Please list any **surgical procedures** you have had:

Surgery Date

Surgery Date

Surgery Date

Surgery Date

Please list **prescribed** medications you are currently taking and for what condition:

Medication Condition

Medication Condition

Medication Condition

Medication Condition

Medication Condition

Please list **over-the-counter** medications you are currently taking and for what condition:

Medication Condition

Medication Condition

Medication Condition

Medication Condition

Medication Condition

Please list any **vitamins, supplements, and herbs** you are taking:

Product Condition

Product Condition

Product Condition

Product Condition

Please mark in the following table how often do you experience the listed emotions and what is the usual cause that triggers them:

Emotion	Never	Sometimes	Often	Always	Caused by
Happy					
Peaceful					
Anxious					
Relaxed					
Joy					
Anger					
Fear					
Worry					
Depression					
Sadness					

FERTILITY HISTORY:

Have you initiated any pregnancies in the past? ❒ Yes ❒ No When?

Have you been evaluated by an urologist? ❒ Yes ❒ No
Diagnosis:

Have you had a semen analysis? ❒ Yes ❒ No
Results:
Date: _____
Count (million cell/ml): _____
Motility (%): _____
Morphology (% normal): _____
Other: _____

Are you taking any medications or supplements? ❒ Yes ❒ No
Please list and describe for what condition:

Have you had any Male surgeries? ❒ Yes ❒ No

Procedure	Date	Result	Comment
Vasectomy			
Vasectomy reversal			
Testicular Biopsy			
Varicocele ligation			
Hernia repair			
Undesenced testicle			
Renoval of testicle			

Have you had your hormones evaluated? ❒ Yes ❒ No

Test	Date	Result	Comment
FSH			
LH			
Testosterone			
Antisperm antibodies			

GENERAL HEALTH HISTORY:

How frequent do you have intercourse? _____ # times per week

Do you have difficulty obtaining or keeping an erection? ❒ Yes ❒ No

Does your penis become warm/hot when aroused? ❒ Yes ❒ No

Do you ever experience burning or itching after intercourse? ❒ Yes ❒ No

On a scale from 1 to 10, (10 being the best) what is your energy level?

Do you tend to be warm or cold?

Do you often need extra blankets or sweaters or can you go outside wearing a t-shirt when it is chilly?

Do you have cold hands and feet? ❒ Yes ❒ No

Do you experience night sweats? ❒ Yes ❒ No

Do you have hot feet at night? ❒ Yes ❒ No

Do you experience sweating upon light exertion? ❒ Yes ❒ No

Do you experience difficulties with urination?

Urgency ❒ Yes ❒ No

Pain with ❒ Yes ❒ No

Frequency ❒ Yes ❒ No

Do you need to get up more than once per night to urinate? ❒ Yes ❒ No

Have you had a history of urinary tract infections? ❒ Yes ❒ No

Do you experience regular bowel movements?

Daily ❒ Yes ❒ No

2-3 time per day ❒ Yes ❒ No

Every other day ❒ Yes ❒ No

Frequent loose stool ❒ Yes ❒ No

Constipation ❒ Yes ❒ No

Alternating diarrhea with constipation ❒ Yes ❒ No

Do you tend to be thirsty or experience dry mouth and throat? ❒ Yes ❒ No

Do you experience dry eyes? ❒ Yes ❒ No

Do you experience ringing in your ears? ❒ Yes ❒ No

❒ High pitched

❒Low pitched

Do you experience low back pain? ❒ Yes ❒ No

Do you have problems falling asleep or staying asleep, or waking nightly at the same time? ❒ Yes ❒ No

Do you tend to get sick easily? ❒ Yes ❒ No

Number of brothers and sisters:

Where are you in the birth order? ❑ Oldest ❑ Middle ❑ Youngest

How many years between you and closest siblings?

Did your mother have any miscarriages?

How old was your mother when you were born?

How was your mother's pregnancy with you? Were there any major stressful events?

DIET, EXERCISE & LIFESTYLE

Do you have a regular exercise program? ❑ Yes ❑ No. Please, describe:

How many meals do you have per day? How many snacks?

Are you or have you ever been on a restricted diet? ❑ Yes ❑ No. What kind?

What foods/flavors do you crave?

Please describe your average daily diet:

Morning	Afternoon	Evening

Dietary preferences:

___ Vegetarian
___ Vegan
___ Raw foods diet
___ Fast food/ burgers/ fries
___ Spicy / hot
___ Sweet

___ Low fat diet
___ High protein/low carb
___ Dairy /milk /cheese
___ Eggs
___ Chicken
___ Fish / seafood
___ Red meat
___ Artificial sweeteners

___ Sour
___ Salty
___ Cold drinks
___ Hot drinks
___Ice chewing
___Extreme thirst
___Thirst with no desire to drink

Do you take any of the following:

Coffee:	❑ Yes ❑ No	#____/week	❑ Regular ❑ Decaf
Alcohol:	❑ Yes ❑ No	#____/week	What? _____
Soda:	❑ Yes ❑ No	#____/week	❑ Diet ❑ Regular
Cigarettes:	❑ Yes ❑ No	#____/day	(Brand:_____)
Recreational Drugs:		#____/week	(Type:_____)

How is your sleep:

❑ I sleep well.
❑ It's hard to fall sleep
❑ It's hard to stay sleep
❑ I wake up every night at _____
❑ I wake up refreshed Γ I wake up tired

How many hours/night do you sleep? _____ What time do go to bed? _____

Do you have recurring dreams? ❑ Yes ❑ No. If yes, explain:

_____

_____

Do you use any of the following products?

❑ anti-perspirant
❑ hair dyes/permanents/relaxers
❑ cellular phone, #of mins per day_____
❑ computer, # hours per day_____
❑ commercial household cleaning products

Mark any of the following symptoms that applies to you in the present or past:

General symptoms
___ Fatigue
___ Sweat without exertion
___ Night sweats
___ Fever / chills
___ Dizziness / vertigo
___ Bleed / bruise easily
___ Low immunity
___ Other _____

Digestion
___ Extreme appetite
___ No appetite
___ Cravings
___ Dieting
___ Tired after eating
___ Bloating
___ Gas
___ Acid regurgitation
___ Heartburn/Ulcers
___ Nausea
___ Vomiting
___ Bulimia
___ Irritability or low energy between meals
___ Fall asleep easily
___ Lie in bed with eyes open
___ Wake at specific times
___ Wake repeatedly
___ Wake frequently to urinate
___ Vivid or Lucid Dreams
___ Wake up not feeling rested
___ Nightmares or frightening dreams
___ Need drugs or supplements to fall asleep

Head, Eyes, Ears, Nose and Throat
___ Dry eyes
___ Spots / flowery vision
___ Blurred vision
___ Poor vision
___ Eye strain
___ Night blindness
___ Cataracts
___ Macular degeneration
___ Bleeding gums
___ TMJ
___ Sores on tongue or mouth
___ Dry mouth
___ Excess saliva
___ Sinus problems
___ Post-nasal drip
___ Sore throat
___ Headaches
___ Swollen glands
___ Difficulty swallowing
___ Other _____

Intestinal
___ Daily Bowel movement
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Anal itching / burning
___ Laxative use
___ Bloody stool
___ Mucous in stool
___ Contain undigested food
___ Anal fissures
___ Intestinal pain/cramping
___ Incomplete evacuation
___ Hard to push out
___ IBS
___ Colitis
___ Gout
___ Gallstones
___ Other _____

Sleep

___ Earaches
___ Tinnitus / ringing
___ Deafness
___ Nosebleed
___ Other_____

Cardiovascular / respiratory
___ Heart palpitations
___ Chest pain
___ Difficulty breathing
___ High cholesterol
___ Varicose veins
___ Blood clots
___ Swollen ankles
___ Heart valve abnormality
___ Shortness of breath
___ Cold hands / feet
___ Dry cough
___ Wheezing
___ Chest tightness
___ Difficult inhalation
___ Difficult exhalation
___ Productive cough (color of phlegm?)
___ Other _____

Skin / hair
___ Dry skin
___ Rashes / hives
___ Eczema
___ Psoriasis

___ Pimples / acne
___ Fungal infections
___ Brittle nails
___ Ridged nails
___ Hair loss
___ Dandruff
___ Other _____

___ Limited range of motion
___ Vertebral disc degeneration
___ Osteoporosis
___ Numbness
___ Carpal tunnel
___ Other _____

Neuropsychological
___ Anxiety
___ Irritability
___ Insomnia
___ Depression
___ Easily stressed
___ Poor memory
___ Seasonal mood disorder
___ Tics
___ Tremors
___ Death of someone close
___ Job stress
___ Recent divorce
___ Currently in therapy
___ Financial setback
___ Other _____

Genito-urinary
___ Urine Clear
___ Urine Cloudy
___ Urine Dark
___ Painful urination
___ Frequent urination
___ Loss of urine when laughing or sneezing
___ Incomplete urination / retention
___ Dribbling
___ Burning urination
___ Blood in urine
___ Wake frequently to urinate
___ Kidney stones
___ Bedwetting
___ Decreased libido / sexual desire
___ Impotency
___ Other _____

Musculoskeletal
___ Spinal pain
___ Joint pain
___ Tendonitis
___ Swelling
___ Arthritis