Whole Health Centers 9075 Forrstrom Drive Lone Tree, CO 80124 Phone: (303) 470-1995 www.wholehealthcentes.com

Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date		First Name	Middle	"Nick	Name"	Last Name		Social Security Number
///	Date of Birth		Age	Marital Status				
M F	Date of Birth	1	Age		riad C	eparated Divorced		
Street Address	/			Single Man	ieu s	City		State Zip
Street Address						City		State
Phone (Daytime)) – Home W	ork Mobile Circ	le One		Alterna	nte Phone # - Home Work M	obile Circle On	ne
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Place of Er	nployment		Occupation		Phone	Numbers of Emergency Contact		
					Primar	y()	Alternate ()
Circle Insurance	Coverage (Plea	ase circle one)						
None	Workers'		Injury I	Health Insurance C	ompany		`	
Would you like t		nthly e-mail acupu			1 3			
E-Mail:		, , , , , , , , , , , , , , , , , , ,						
How did you hea	ar about us? Ple	ase circle one and	write the name					
Current Pati	ent:	Doctor	Advertisen	nent:	Friend:	Incurance	Other:	
Current rati	CHt			lent.	i riciid.	Insurance:		
Chief com	nlaint·							
How long?	Pium			Hoy	v ofte	en:		
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					ounte	r/prescription meds), o	other?	
		•				uses side effects?		
How does t	this affect	your life?						
Affect your	r family? _				A	ffect your sleep? fect your hobbies?		
Affect your	r work?				_ Af	fect your hobbies?		
What is you	ur goal/pla	n if the prob	lem contir	nues 5/10/20	years	s?		
C 1.4	110							
Complaint	#2:			Цох	v ofte	en:		
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Dogoribo th	o worst it	an ba	yie, drug, e	ic.):				
What treatr	nonte hove	von tried (i	oo/boot/ros	ut/over the e	ounto	r/prescription meds), o		
		•				uses side effects?		
How does t	this affect	vour life?	ixes probit	ZIII!	_ Cai	uses side effects:		
Affect your	r family?	your me			Α	ffect your sleep?		
Affect your	r work?				Af	fect your hobbies?		
What is you	ur goal/pla	n if the prob	lem contir	nues 5/10/20	years	s?		
Other Con	nplaints:							
	1							
3)				4)				

a scale of 1-10, rate y	our commitment to	get	MEDICA	L CONDITIONS	ALLE	ALLERGIES		
of the problem(s) and			Please List	conditions & surgeri	es you have had	Medica	tions, Seasonal,	
ve you had acupunctu			and year dia	agnosed.		Enviro	nmental, Food.	
ves where/who								
res, where/who y concerns or fears ab	out the needles?							
you what?	out the needles							
res, what? nat are your goals of y	cour course atura via							
1								
2								
3								
MEDICATIONS – Ple	ease list all prescription	n medicatio	ons vou use. It	nclude those which	you may only	v use occas	sionally	
Remember inhalers, eye					i you may om	y use occur	ordinarry.	
Prescription Name			Long	Dose	How (Ofton	Last Dos	
1 rescription realic	Purpose	пом	Long	Dose	HOW C	Hen	Last Dos	
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SYMPTOMS - *	**NOTE**: For	each svm	nptom vou	currently have	rate its sev	verity fr	om 1- 5	
<u>SYMPTOMS</u> – *	** <u>NOTE**: For</u>						om 1- 5	
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LIVER / GALLBLADL	OER (5 being t)	he worst) HEART/). LEAVE SMALL INTI	BLANK IF NO	OT APPLIO SPLEEN /	CABLE.	CH CH	
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Mild Fever Comes & Goes

Smoke Cigarettes

Feel Cold Easily

Low Sex Drive

Cavities

Fear

Excess Sexual Desire Poor Memory Loss of Hair Hearing Problems

Craving / Avoiding Salty Foods

Hot Flush / Night Sweating

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "C" under the appropriate person's column. "P" should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the reverse side of this form.

	You	Father	Mother	Spouse	Brotl	ner(s)	Siste	er(s)	Children		
Age											
AIDS / HIV											
Alcohol											
Anxiety											
Arthritis									Z		
Asthma / Hay Fever / Allergy											
Back Trouble											
Bursitis)		
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis						1					
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble						P					
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Tobacco											
Weight Problem											
Other Emotional			X X								
Problems:			AIL								
Other:											

If any of the above family members are deceased, please list their age at death and cause. MUSCULOSKELETAL ☐ Muscle Cramps – Where? \square Muscle Pain / Rheumatism – Where? \square Arthritis – Where? ☐ Joint Swelling – Where? \square Tendonitis – Where? ☐ Bursitis – Where? Please mark problem areas on diagram: Describe Pain and Location □ Sharp Burning Aching □ Fixed Other:_ Aching Sharp Burning Fixed Other:_

Sharp

Fixed

Burning

Other:_

Aching

Women Only	Men Only							
Hysterectomy – Ovaries Removed?	 □ Impoten e □ Discharg from Penis □ Testicular Pain or Lump □ Premature Ejaculation □ Low Sex Drive 							
Post-menopausal Bleeding □ Yes □ No	Men and Women							
When did your last period end?	<u>Supplements</u>							
Number of days for monthly cycle?	Name Purpose How Long							
Number of days bleeding lasts?								
Describe Menstrual Flow: ☐ Heavy ☐ Moderate ☐ Light ☐ None Color of Menstrual Flow: ☐ Dark ☐ Bright Red ☐ Slightly Reddish								
Birth Control:	Diet							
□ None □ IUD □ Birth Control Pills								
□ Spermicides □ Barriers	What kinds (circle) How much per day/week Sug r: Candy							
Do You Suffer From:	Cookies / Baked goods Regular Soda / Diet Soda							
□ Cramping (Mark as appropriate) □ Mo erate □ ild □ Before Perio □ During Period □ After Period □ Clotting (Mark as appropriate) □ Dark in Color □ Bleeding Between Periods □ Infertility □ Pelvic Inflame. Disease □ Ovarian Cysts □ Endometriosis □ Hot Flashes □ M stitis □ B east Cysts □ Yeas Infection / Vaginitis / Other Discharge □ Premenstrual Syndrome (Mark as appropriate) □ Fluid Retention □ Cravings □ Fluctuating Emotions □ Irritability □ Tenderness in Breasts □ Depression □ Fatigue	Chocolate Diary: Milk Cheese Yogurt Ice-cream White Flour: Bread Pasta Coffee Alcohol Protein 50g per day? Eggs Dark green/vegetables Fruits Eat Breakfast? Eat fast food / on the run? Additional Notes							
	Thank you for completing this form. Your time is greatly appreciated and we value this opportunity to serve you!							

Women's Fertility History CONFIDENTIAL

Name	of your	doctor /	fertilit	y specialist: Co												
Start date: month/year Etc.)				Name of person who told you about us? Current Month Treatment Plan						(IVF / IUI / Natural / Tests /						
1	DI	12 -4 11	T	1	J C4*1	•4 4	_ 4	4 (! 1	1!	11	11	\ -				
Date	Natu	ral, IUI	ow al	I pregnancie Medication Used					Pregnan Yes/No	су	If M	iscarri	Other Comment			
	IVF, Other Used					Follicles				3 1	naicate a	at wm	ch Week	and Locations		
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2.				f these diagn									•			
_	High F	FSH / AN	ИΗ	Uterine Fibroi	ds / Polyps	Endo	ometri	iosis / Ad	hesions	PCC	OS P	OF	Low Progesterone Level			
Date	0.1															
	Othe	rs:							_							
3.	Have	von eve	r hav	e any of thes	e infertility	tests (or pr	ocedure	s?							
	Laparo		1 IIu v		osalpingogra		or pr	Others		_						
Date	1				1 0 0	1 7										
				f these? If ye					7							
Pregna	ncies	Childre	en	Miscarriages	Abortions	s Ectopic D&C			Abnormal Pap Smear Others					thers		
5	Other:							,								
		nenses h	egan?						Do you	ı have 1	o do a C	lomic	l challeng	e test?		
Do you	ı take bi	rth conti	ol?	If	yes, how lon	g? Do you ov				ovula	ve to do a Clomid challenge test?ulate on your own?					
List na	me of b	irth cont	rol						How ca	an you	tell you	ovula	te?			
				ted out for fert		s?	_		Which	day of	your cy	cle _	to _			
				ng to get pregr		nth/rras	-				e BBT t		? ire there f	_	maniad	
Do voi	/ 3 i get rec	at Da _.	y 10 east in	at fections?	How o	nth/yea	II')		• •	•	w many to	•		rom one	period	
Do you	i get ice	differit y	cast III.	rections:	TIOW (which day of your cycle?					
												<i>J</i>				
6. L	ist any			ns before peri		7			period e			_	eck each			
			Days fore	1 Week Before	2-3 Days	(ple		mptoms heck eacl	, dow)	Day 1	Day 2	Day 3	y Day	Day 5	Day 6-7	
		Del	iole	Before	Before	(pic	ease ci	HECK Caci	i day)	1	2	3	4	3	0-7	
Br	east				Before	Do	you ha	ave Back	Pain?							
	erness						<i>J</i>									
Depr	ession					Cra	-	ight, Me	dium,							
	1					<u> </u>		evere)	D 1/							
Fat	igue							ght Red / led / Bro								
Low	Back								_							
	ain					How Heavy is Flow (Light, Normal, Heavy)										
	Break	1						re Clottin								
	Out								_							

Other

Is there Spotting?