Welcome to Affinity Acupuncture and Rolfing/

Dr. Connie Christie, DAOM, LAc

Please email to affinityacu@gmail.com OR fax to 424-228-3035
Call (310) 390-7500 **Text** (424) 201-5093

Please note that all information is strictly confidential.

First Name: Today's Date:

Last Name: Pronouns:

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 text? Y N

Occupation: Name of Company:

In Case of Emergency Contact:

Relationship & Phone:

Family Physician: Phone:

How did you hear about us?

Insurance Information: If Affinity Acupuncture and Rolfing 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: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am financially responsible for any balance not paid by my insurance company or Medicare. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature:_____ Date_____

Reason for Today's Visit:

What is the reason for your visit today?

_____

How, when and where did this condition begin?

_____

What types of treatments have you tried, if any?

_____

How does this condition impair your daily activities?

_____

What makes it better or worse?

_____

Please list your main health problems that you would like to be free of in order of importance:

1. _____
2. _____
3. _____

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: check 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:

How good do you feel your nutrition is?

_____

Typical

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Worst food in your diet? _____

What foods do you crave?_____

Water intake per day? _____

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 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

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

Ear pain Dry mouth Migraines Ringing in ears

Clogged/popping ears Frequent headaches

Body Fluids: Do you perspire abnormally during the day?_____At night?_____
Are you always thirsty?_____

Men Only:

Have you been diagnosed with prostate problems? Yes No
Do you experience premature ejaculation? Yes No
Do you have problems with Impotence? Yes No
Have you been diagnosed with Infertility? Yes No
Diseases/ Disorders:

Women Only:

At what age did you get your first period?_____

What was that like?_____

Date of last menstrual cycle?_____

Are you currently using contraception? Yes No How long have you used contraception throughout your life?_____

Dates/Type:_____

Are you pregnant now? Yes No

How many pregnancies have you had?_____

No. of deliveries:_____

Dates:_____

No. of Terminations:_____

Dates:_____

Complications?_____

No. of Miscarriages:_____

Dates:_____

Complications?_____

Maternal Family History of (please check): Infertility Fibroids Endometriosis

Cancer (type)_____ Menstrual Problems PMS Menopause

Medications your mother took when she was pregnant with you (if any)

_____

Number of days from the start of one period to the start of the next:_____

Are your menstrual cycles spaced regularly? Yes No

Average number of days of flow:_____ Flow is: Light Normal Heavy

Color is: Pale Normal Dark Bright Red Brown

Are blood clots present? Yes No

Does your period cause you pain or cramping? Yes No

When? Before During After Period

Do you get nausea or vomiting with your period? Yes No

When? Before During After Period

Do you experience any of the following before your period each month?

Water retention Breast tenderness or swelling Mental depression Irritability

Food cravings Migraines Other_____

Do you ever bleed or spot between periods? Yes No

Do your bowel movements become loose at the beginning of your period? Yes No

Do you have any vaginal discharge between periods? Yes No Color_____

Do you have/have you ever had?

Abnormal pap smear? Yes No When/Why?_____

A cervical biopsy, operation, cauterization, conization? Yes No

Venereal disease? Yes No Chlamydial infection? Yes No

Yeast infections? Yes No Sores on your genitals? Yes No

Uterine fibroids or polyps? Yes No Endometriosis? Yes No

Varicose veins? Yes No Sore heels when walking? Yes No

Incompetent Cervix? Yes No Painful intercourse? Yes No

Numb legs/feet when standing still? Yes No

Pelvic inflammatory disease? Yes No

Difficulty experiencing orgasm? Yes No

Were you treated for it? Yes No

How_____

Date of last pap smear? _____

Have you been diagnosed with pelvic adhesions? Yes No

Have you been diagnosed with any pelvic abnormalities? Yes No

Have you experienced menopause? Yes No When?_____

If you are experiencing menopausal symptoms, please describe:

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
high normal low	libido	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	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: _____

Women's Fertility Worksheet

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

Date: _____

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? _____

When was that diagnosis given? _____

What is that diagnosis?

Male factor? _____

Female factor? _____

Why do *you* think you aren't getting pregnant?

_____

What fertility treatments have you tried, when and what happened?

What	When	Where/By Whom

What is your plan from here?

_____

Signature:_____ Date: _____