Jaesun Yoo Acupuncture P.C.

Please take time to fill out this questionnaire to the best of your ability. Please add details when relevant. All responses are kept confidential.

PATIENT INFORMATION (please print)				
First name:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms. ❑ Dr.	Sex: ❑ M ❑ F	Today's date:
Last name:	Birth date: / /		Age:	Single / Partner / Div / Sep / Wid / Married
Email:	Soc Sec:			Phone (home):
Home address:		Apt #:		Phone (work):
City:	State:	ZIP:		Phone (cell):
Referred by:	Employment Status:	❑ F/T ❑ P/T ❑ unemployed ❑ school ❑ at home ❑ retired ❑ disabled		Occupation:
Reason for Visit:				
History of Problem (length, severity, level of interference in daily activities):				
Have you had Acupuncture before? ❑ Yes ❑ No	Chinese Herbal Medicine? ❑ Yes ❑ No	Primary Physician:		
Western Medical diagnosis (if applicable):				Phone (Phys):
Other medical treatment received:				
Medical Insurance:				
Subscriber Name:	Relationship:			Phone (Ins.):

Please list the family members you live with:	Please list any prescription or over-the-counter medication you are currently taking:
Do you have any housing problems? (heating, rats, roaches, paint peeling, other toxins)	Please list any herbal medicine and other supplements you are currently taking:
Do you crave certain foods? Do certain foods "disagree" with you?	
	Please list any allergies (foods, drugs, environmental, etc.):
Have you ever experienced an emotional, spiritual or physical incident from which you feel you have never recovered your previous level of health? Please discuss:	Explain any hospitalizations or surgeries, including dates:

How often do you use:	Daily	Once a week	Rarely	Never
Cigarettes / Cigars				
Alcohol				
Drugs				
Coffee				
Soft Drinks				
Artificial Sweeteners				

How often do you participate in the following physical activities?	
Running / Walking	
Swimming	
Yoga	
Biking	
Weight Training	
Gym / Fitness Class	
Other:	

Patient Intake Form cont'd.

Please indicate which of the following symptoms you have had **recently** (past 1-3 months).

Gan

____ Blurred vision / poor night vision
____ Brittle nails
____ Depression / Stress
____ Dizziness
____ Emotional eating
____ Feeling of lump in throat
____ Genital itching / pain / lesions
____ Headaches / Migraines
____ Irritability / frustration / impatience
____ Muscle twitching / spasm
____ Neck / shoulder tension
____ PMS
____ Red / Dry / Itchy Eyes
____ Sensation or pain under rib cage
____ Sighing
____ Unfulfilled desires
____ Visual problems / floaters

Xin

____ Aversion to heat
____ Bitter taste in mouth
____ Chest pain / tightness
____ Forgetful
____ Insomnia / Sleep problems
____ Lack of joy in life
____ Palpitations
____ Restless / easily agitated
____ Tongue / mouth ulcers / cankers
____ Vivid dreams

Shen

____ Ankle swelling
____ Bladder infection
____ Cold hands / feet
____ Crave salty food
____ Fear
____ Feel cold easily
____ Frequent urination
____ Hearing problems
____ High sex drive
____ Lack of bladder control
____ Loss of head hair
____ Low sex drive
____ Night sweats / hot flashing
____ Poor long-term memory
____ Tinnitus
____ Wake to urinate

Pi

____ Abdominal pain
____ Alternate constipation / loose
____ Aversion to cold
____ Bad breath
____ Bloating / gas
____ Bruise easily
____ Cold nose
____ Constipation
____ Crave sweets
____ Difficulty getting up in the morning
____ Fatigue / after eating
____ Foggy mind
____ Heartburn
____ Heaviness in the head / body
____ Hemorrhoids
____ Increased appetite
____ Increased thirst
____ Intestinal pain / cramping
____ Loose stool
____ Muscular tired / weak
____ Nausea / vomiting
____ Overweight
____ Pensive / over-thinking
____ Poor appetite
____ Poor digestion
____ Prefer Warm / Cold drinks
____ Sweat easily
____ Unusual bleeding (nose, anus, etc.)
____ Water retention
____ Yeast infection

Fei

____ Allergies / Asthma
____ Alternate fever / chills
____ Cough with phlegm
____ Dry cough
____ Dry mouth / nose / throat
____ Grief / Sadness
____ Itchy / painful throat
____ Nasal discharge / drip
____ Shortness of breath
____ Sinus infection / congestion
____ Skin rashes / hives
____ Snoring
____ Weak immune system

Emotions

____ Absentminded / loss of memory
____ Angered easily
____ Annoyed by little things
____ Changes in sexual energy
____ Considered suicide
____ Difficulty making decisions
____ Difficulty relaxing
____ Dislike criticism
____ Experienced sexual abuse
____ Family problems
____ Feeling of depression
____ Frequent crying
____ Frightening dreams or thoughts
____ Hopeless outlook
____ Lack of concentration
____ Lonely or depressed
____ Nail biting
____ Nervous with strangers
____ Nervousness or anxiety
____ Problems at work
____ Sexual difficulties
____ Shy or sensitive
____ Sought psychiatric help
____ Worry a lot

Occupation: please explain your duties and the stress levels involved

Personal Impact: please explain any personal stresses in your life

Passions and Hobbies: describe things you do that make you happy

Patient Intake Form cont'd.

Print the names of relatives (living or deceased) in the rows to the left. Place a (√) in the appropriate column for any illnesses that you or the relatives listed have had.

Were you adopted? Yes No	Allergies	Anemia	Anorexia	Arthritis / Gout	Asthma	Bleeding / Bruising Problems	Bulemia	Cancer or Tumors	Convulsions / Epilepsy	Diabetes	Drinking or Drug Problems	Eczema	Emphysema	Gallstones	Heart Trouble	Hepatitis	High Blood Pressure	Frequent Infections	Kidney or Bladder Problems	Mental Illness	Migraines	Abnormal Periods	Psoriasis	Pneumonia	Polio	Prostate Problems	Rheumatic Fever	Stomach or Intestinal Disease	Stroke	Thyroid Problems	Tuberculosis	Ulcers	Venereal Disease	Weight Problems
You																																		
Father																																		
Mother																																		
Siblings (list)																																		
Children																																		
Grandparents																																		

Do you have a partner with whom you have been trying to conceive? Yes No

What is his / her name?

How long have you been married or living together?

Is he / she supportive of your wish to conceive? Yes No

Describe your relationship:

Have either of you had a Western medical diagnosis relating to fertility? Yes No If yes, when?

How long have you been trying to conceive?

If yes, please describe the diagnosis for her -

For him -

Have you ever undergone assisted reproductive fertility treatments? (IUI, IVF) Yes No

Clinic	Month / Year	Type of treatment	Results

Are you using donor sperm/ egg? Yes No If yes, why? Female partner | male partner had semen issues | other

Rate your level of sexual desire (mental interest) Low | Average | High

Has this level changed? Decreased | Increased | Unchanged

What is your orgasm frequency/ intensity? Low | Average | High

Has this level changed? Decreased | Increased | Unchanged

Have you been exposed to or received chemotherapy/radiation? No Yes
If yes, when?

Height _____ ft _____ in Weight _____ lbs

Patient Intake Form – Male Fertility

Name:_____			
How long have you and your partner been trying to conceive?		Height _____ ft _____ in Weight _____ lbs	
How would you describe your sexual energy?		☐ Below normal	☐ Normal
Have you had a recent physical exam?		☐ Yes ☐ No	
Do you or did you have an undescended testicle?		☐ Yes ☐ No	
Have you ever had any urologic surgeries?		☐ Yes ☐ No	
Hove you experienced erectile dysfunction?		☐ Yes ☐ No	
Have you had difficulty ejaculating?		☐ Yes ☐ No	
Have you had exposure to any known environmental toxins or hormones?		☐ Yes ☐ No	
Have you experienced any penile discharge?		☐ Yes ☐ No	
Do you regularly experience nocturnal emission?		☐ Yes ☐ No	
Do you have high cholesterol?		☐ Yes ☐ No	
Have you experienced a high fever (above 101) in the last 6 months?		☐ Yes ☐ No	
Do you currently have any prostate conditions?		☐ Yes ☐ No	
Do you or have you ever had urinary infections or STDs?		☐ Yes ☐ No	
Have you ever taken testosterone supplements / drugs?		☐ Yes ☐ No	
Have you had your testosterone levels checked recently?		☐ Yes ☐ No	
Have you been diagnosed with small or soft testis?		☐ Yes ☐ No	
Have you been checked for a blockage of your reproductive tract?		☐ Yes ☐ No	
Have you had a fertility workup?		☐ Yes ☐ No	
If yes, what was your sperm count?	Number: _____	☐ Below normal	☐ Normal
What was the sperm motility?	_____	☐ Below normal	☐ Normal
What was the sperm morphology?	_____	☐ Abnormal	☐ Normal
Other comments:			
Relationship: please describe your relationship			
Thank you for providing such detailed information. Each piece you provide helps in better understanding the path you have been on up to the outset of your treatments. What expectations do you have of our practice? Please provide the wellness goals you wish to attain here:			