The Huntington Wellness Center
1789 E. Jericho Tpke., Suite 200
Huntington, NY 11743
Phone 631-424-8601 Fax 631-424-8603

Date:

Last name/	First name/

Circle: **Mr. Ms. Mrs. Dr.**

Birth date/	Age/	Circle # of preferred contact
Address		Phone (home)/
City/		Phone (work)
State/	Zip/	Phone (cell)
Email/		**Occupation/**

Have you had Acupuncture before? Yes No
Chinese herbal medicine? Yes No

Reason for Visit/

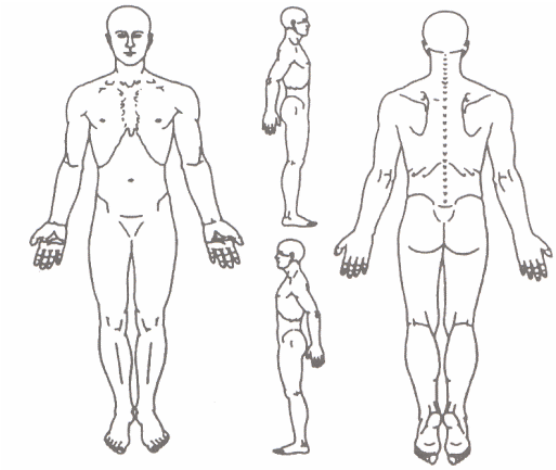
Family Physician name/	Family Physician phone/
Western Medical Diagnosis (if applicable)	

Other medical treatment received (circle)/ Fertility Clinic Physiotherapy Massage Naturopathy Chiropractic Other:

Please indicate with a '**P**' (past) '**C**' (current) '**F**' (family) if any of the conditions below apply:

	Heart Conditions		Stroke		High blood pressure		Low blood pressure
	Diabetes		Deep vein thrombosis		Neurological		Spinal or head injury
	Respiratory condition		Kidney disorder		Cancer		Hepatitis
	HIV/AIDS		Sprain/Strain/Fracture		Osteoporosis		Headaches/migraines
	Jaw pain		Arthritis		Dizziness/fainting		Contagious illness
	Skin condition		Digestive problems		Hemophiliac		Wear a pacemaker
	Lung condition		Epilepsy		Possibility of Pregnancy		Upcoming surgeries

On the figures below, please circle the areas of concern/pain;



Please list any prescription medication or over the counter drugs currently taking:	
1.	2.
3.	4.
5.	6.
Please list herbal medicine and other supplements currently taking:	
1.	2.
3.	4.
5.	6.
Please list ant allergies (food, drugs, environmental, etc.):	
1.	2.
3.	4.
Have you been hospitalized and/or treated for any infectious/serious conditions or surgeries? If yes, briefly explain for what condition or reasons and the year (below).	

Do you use the following? If so how often? Cigarettes:_____ Alcohol: _____ Drugs:_____ Coffee:_____ Soda:_____

Do you participate in the following physical activities? If so, please indicate how often:			
Yoga:	Running:	Fitness Class:	Gym:
Biking:	Swimming:	Walking:	Other:

How did you hear about Ronald Sandoval, L.Ac.? (internet, Friend, Doctor, Fertility Clinic, Seminar, Magazine, TV, news)

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For Each symptom below that you currently have, rate its severity from 1-5 (5 being the worst). Leave blank if N/A

Liver
___Irritability/frustration/impatient
___Depression
___Stress
___Emotional eating
___Unfulfilled desires
___Visual problems/ floaters
___Blurred vision/ poor night vision
___Red/ Dry/ Itchy eyes
___Headaches/ Migraines
___Dizziness
___Feeling lump in throat
___Muscle twitching/ spasm
___Neck / shoulder tension
___Brittle nails
___Sighing
___Sensation or pain under rib cage
___PMS
___Genital itching/ pain/ rashes

Heart
___Palpitations
___Chest pain/ tightness
___Insomnia/ Sleep problems
___Restless/ easily agitated
___Vivid dreams
___Lack of joy in life
___Forgetful
___Aversion to heat
___Bitter taste in mouth
___Tongue/ mouth ulcers/ cankers

Kidney
___Frequent urination
___Bladder infection
___Lack of bladder control
___Wake to urinate
___Feel cold easily
___Cold hands/ feet
___Night sweats/ hot flushing
___Low sex drive
___High sex drive
___Loss of head hair
___Hearing problems
___Crave salty food
___Fear
___Poor long term memory
___Ankle swelling
___Tinnitus (ringing in ears)

Lung
___Dry cough
___Cough with Phlegm
___Nasal discharge/ drip
___Sinus infection/ congestion
___Itchy/ painful throat
___Dry mouth/ throat/ nose
___Skin rashes/ hives
___Snoring
___Grief/ sadness
___Shortness of breath
___Allergies/ asthma
___Weak immune system
___Alternate fever/ chills

Spleen
___Heaviness in the head/ body
___Fatigue/ after eating
___Difficult getting up in morning
___Water retention
___Muscular tired/ weak
___Bruise easily
___Unusual bleeding (stool, nose, etc.)
___Bad breath
___Poor appetite
___Increased appetite
___Crave sweets
___Poor digestion
___Nausea/ vomiting
___Bloating/ gas
___Hemorrhoids
___Constipation
___Loose stool
___Alternate constipation/ loose
___Abdominal pain
___Intestinal pain/ cramping
___Heartburn
___Pensive/ over-thinking
___Overweight
___Foggy mind
___Yeast infection
___Aversion to cold
___Cold nose
___Increased thirst
___Prefer warm/ cold drinks
___Sweat easily

Besides fertility, list your main health concerns in order of importance to you:	1.	2.
	3.	4.

On a scale of 1-10, how would you rate your daily energy level (10 being the best)?

How many times in your life have you taken Antibiotics (approx. #)? How many times have you taken oral steroids?

What is your occupation? Do you enjoy your work? How many hours per week do you work? Is it stressful? What are your duties?

Please describe in general what you eat, and what do you crave? (sweet, spicy, salty, organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.)

Are your bowel movements regular? How many times per day/week? Are they formed, loose, constipated, or do they alternate from loose to difficult to pass?

Do you have trouble falling asleep? Are you a light sleeper? How many hours per night? Do you have vivid dreams? If so, what are they about? Wake and have difficulty falling back to sleep?

Do you experience urinary frequency, urgency, burning, dribbling, retention? What color/shade of yellow is it? Do you have a history of urinary tract infections?

If you were asked to describe yourself from an emotional standpoint, what would you say? (i.e. irritable, worrier, anxious, sad, impatient, stressed, etc.)?

How many glasses of water do you drink in a day?

Please print, complete, and fax in forms before your initial appointment. Thank you.

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Date last menses began/

Is your menstrual cycle: Regular____ Irregular____

How old were you when you had your first menstruation?	How many days do you bleed in total/
	Menstrual cycle length (i.e. 26-30 days)/

Describe your flow: Heavy ____ Light____ Average ____ **Consistency of blood:** Watery ____ Thick ____ Average ____
Does your blood contain clots? Yes ____ No ____ … … **At which point during the cycle?** Start ____ Mid ____ End ____
Describe the color of your blood: (red, dark red, brown, purple, brownish red, bright red, pink, etc)

Do you experience menstrual pain? Yes___ No ___	Before menses ___ During _____(please specify which days) After ___
What relieves the pain?	Stabbing ___ Cramping ___ Dull ___ Heavy ___ On/off ___

Do you experience Pre-menstrual symptoms (PMS)? Please check all that apply

Breast tenderness ___ Cramps ___ Acne ___ Change in Bowel ___ Bloating ___ Headaches ___ Nausea ___ Moodiness ___
Fatigue ___ Night sweats ___ Sleep disturbances ___

Please list any other pre-menstrual symptoms

Do you ovulate on your own? Yes ___ No ___ What Day?	Do you chart your cycle (circle) BBT / Ovulation sticks / Saliva
Do you experience pain around ovulation? Yes ___ No ___	Do your breasts get tender around ovulation? Yes ___ No ___
Do you notice stretchy clear egg white slippery cervical mucous around ovulation? Yes ___ No ___	

How many times have you been pregnant? _____ How many times have you given birth? _____
Ages of children _____ Sex of children _____ Given names _____
Have you had any miscarriages? Yes ___ No ____
If yes, how many, at how many weeks pregnant, and in what year(s)?
_____
How many times have had a D&C performed? _____
How many abortions have you had? _____ In what year(s)? _____

Were there any problems that occurred during these pregnancies? _____

Have you ever been diagnosed with:			
STD?	Yes ___	No ___	Date of last pap smear: _____ / _____ /_____(dd/mm/yy)
Pelvic inflammatory disease?	Yes ___	No ___	Have you ever had an abnormal pap smear? Yes ___ No ___
Uterine fibroids?	Yes ___	No ___	
Polyps?	Yes ___	No ___	Have you ever had a cervical biopsy or operation? Yes ___ No ___
Pelvic adhesions?	Yes ___	No ___	
Prolapsed uterus?	Yes ___	No ___	Do you get yeast infections regularly? Yes ___ No ___
Unique shape of uterus	Yes ___	No ___	
Endometriosis?	Yes ___	No ___	Do you get bladder infections regularly? Yes ___ No ___
PCOS (polycystic ovarian syndrome)?	Yes ___	No ___	If answered yes, list STD's: _____

Do you experience vaginal discharge? Yes ___ No ___
If yes, what color?
White ___ Yellow ___ Green ___ Pinkish ___ Red ___
If yes, what consistency?
Watery / thin ___ Thick ___ Sticky ___
If yes, does it have foul odor? Yes ___ No ___

Have you taken oral contraceptives? Yes ___ No ____
If yes, for how long? _____
When did you stop? _____
Have you ever had an IUD? Yes ___ No ____
Have you ever taken Depo-Provera? Yes ____ No ____

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Do you have a single partner with whom you have been trying to conceive? Yes____ No ____
How long have you been married or living together? What is your partner's name?
How long have you been trying to conceive? Are they supportive of your wishes to conceive? Yes ____ No ____

Have either you or your partner had a western medical diagnosis relating to fertility? Yes ____ No ____
What was the diagnosis? Who made the diagnosis?

Have you had any hormone lab tests performed? (i.e. 3 / 21)			
FSH……	___ Normal	___ High	___ Low
Estrogen, E2…..	___ Normal	___ High	___ Low
Progesterone…..	___ Normal	___ High	___ Low
Prolactin…….	___ Normal	___ High	___ Low
Thyroid……..	___ Normal	___ High	___ Low
Testosterone….	___ Normal	___ High	___ Low
Other: _____	___ Normal	___ High	___ Low

Have you taken medication to help you ovulate?
Yes ___ No ___
If yes, what kind? _____
For how many cycles? _____

Have you had your uterine/fallopian tubes evaluated medically (HSG)? Yes ___ No ____
What were the results?
_____
Have you had any tubal operations? Yes ___ No ___

Have you ever undergone assisted reproductive fertility treatments? (IUI, IVF, superovulation, etc.)

Yes ____ No ____

Month/Year	Type of Treatment	Clinic	Results

How did you respond to the fertility treatments? Poor ____ Good / average ____

Are you using donor sperm? Yes ____ No ____ **If Yes, why?** (circle) female partner / male partner has semen issues

How is your sexual desire (mental interest) ? Low ____ Normal ____ High ____

How is your sexual arousal (physically / orgasm) ? Low ____ Normal ____ High ____

Do you use vaginal lubricants? Yes ____ No ____

Have you been exposed to or received chemotherapy or radiation? Yes ____ No ____

Do you have excessive facial / body hair? Yes ____ No ____

Do you have excessive oily skin? Yes ____ No ____

What is your weight? _____ How tall are you? _____

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Patient Information Release Request Form

I, _____(please print name) give full consent so that Ronald Sandoval, L.Ac., may consult freely with other physicians and healthcare professionals (of which whose care I am under) regarding any of my medical treatments or relevant information. This could include the exchange of both verbal and written communications (including lab work).

(to be filled out by our staff)

The following is an authorization to provide Ronald Sandoval, L.Ac with the following information:

- o All recent lab work results
- o All medical records
- o All semen tests
- o Other: _____

I am nineteen years of age or older:

- o Yes
- o No

Client/Patient Signature: _____ Date: _____

Signature of parent or guardian (if applicable): _____

Thank you for your prompt attention to this request. Please send information by fax to 631-424-8603. If you have any questions, please feel free to contact our office at 631-424-8601.

Ronald Sandoval, M.S., L.Ac