Men's Fertility History

Check the boxes that apply even if you answered similar questions in the previous form. It helps us to determine your diagnosis and treatment plan to effectively enhance your reproductive health.

How long have you been trying to conceive? ____

Have you ever been diagnosed with a varicocele? Yes ☐ No ☐
If yes, when? ______________________________

Have you had any urological surgeries? Yes ☐ No ☐

If yes, when and please list surgeries? ____

Have you had a full fertility workup? Yes ☐ No ☐

If yes, what was your sperm count? Below normal ☐ Normal ☐ Number ________________
What was the sperm motility? Below normal ☐ Normal ☐ Number ________________
What was the sperm morphology? Below normal ☐ Normal ☐ Number ________________

Do you have or experience any of the following?	Yes	No
Low testosterone levels	☐	☐
Low back pain	☐	☐
Cold in lower extremities	☐	☐
Dizziness	☐	☐
Aversion to cold	☐	☐
Low libido	☐	☐
Erectile dysfunction	☐	☐
Is your urination:		
Frequent	☐	☐
Scanty	☐	☐
Dark yellow	☐	☐
Difficult	☐	☐
Painful	☐	☐
Urgent	☐	☐

Do you or have you experienced any of the following?		
Prostatitis (painful condition of the prostate)	☐	☐
Pain in lower abdomen	☐	☐
Seminal duct blockage	☐	☐
High stress level	☐	☐
Painful feeling in testicles	☐	☐
Nocturnal emissions	☐	☐
Exposure to environmental toxins or hormones	☐	☐

Acupuncture Intake Form – New Moon Wellness

Name ____________________________________ Birthdate _______________ Home Phone (____)__________________

Street ___________________________________ Weight _______ Height ______ Cell Phone (____)___________________

City _____________________________________ State _______ Zip ________ Work Phone (____)___________________

Email Address ______________________________________ (add to preferred client list to receive promotional mailings?) YES NO

Physician ____

Occupation ___________________________ Emergency Contact ___________________________ Phone # (____)___________________

Main Problem ____ Onset ______________________________________

Other Concurrent Therapies ____

Please check how you found us: Doctor/health care provider: please provide name__________________________________

Alternative Practitioner: please provide name ____________________________

Friend or family member: please provide name ________________________Website: ____ Classes ____

In House Referral ____ Event ____ Walking by ____ Other ____

Past Medical History: (circle and include date)

Diabetes High Blood Pressure Heart Disease Hepatitis Seizures Cancer _____________
Rheumatic Fever Thyroid Disease Other ___________________________________

Surgeries: ____

Significant Trauma: (auto accidents, falls, etc.) ____

Allergies: (drugs, chemicals, foods) ____
_
Medicines taken within the last two months: (including vitamins, over-the-counter drugs, herbs, etc.) ________________________

Mark areas affected by pain or discomfort on chart.

Please describe pain below or add other comments

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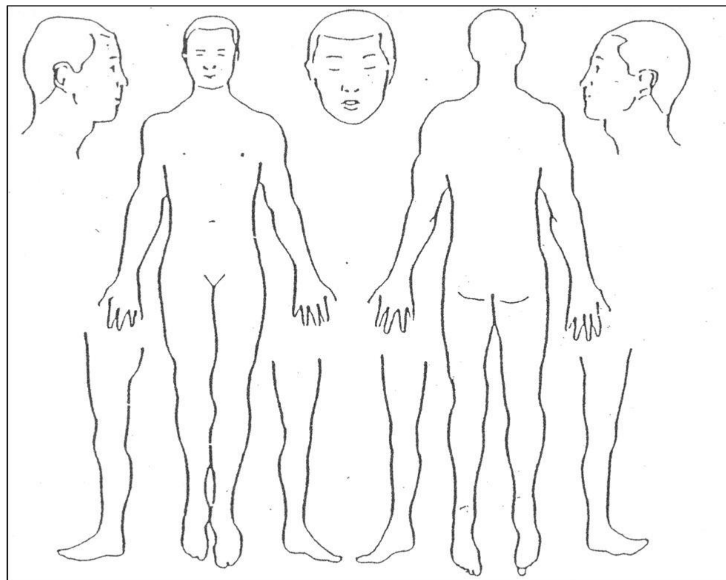

Indicate health concerns or symptoms with:
one check for any condition that you sometimes experience, two checks for those which occur often, three checks for symptoms that are a major concern.

WATER ELEMENT

- ❑ Hearing loss
- ❑ Dizziness
- ❑ Lower back ache/neck pain
- ❑ Sinus congestion
- ❑ Edema
- ❑ Darkness under eye
- ❑ Emotional Instability
- ❑ Aversion to cold
- ❑ Hair thinning or loss
- ❑ Pre-mature aging
- ❑ Frequent urination
- ❑ Kidney Stones
- ❑ Perspire very easily
- ❑ Weakness of legs/knees
- ❑ Asthmatic cough
- ❑ Rapid weight change
- ❑ Loose teeth
- ❑ Reduced sexual energy
- ❑ Thyroid problems
- ❑ Diabetes

WOOD ELEMENT

- ❑ Headaches
- ❑ Migraines
- ❑ Ringing in the ears
- ❑ Poor eyesight
- ❑ Eye infections
- ❑ Dry eyes
- ❑ Eczema
- ❑ Shingles
- ❑ Herpes simplex
- ❑ Warts
- ❑ Nervousness
- ❑ Convulsion, spasms
- ❑ Irritability
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Ulcer
- ❑ Vomiting
- ❑ Gallstones
- ❑ Indecisive
- ❑ Fullness below ribs
- ❑ Shoulder/neck tension
- ❑ Insomnia 11pm-3am

FIRE ELEMENT

- ❑ Dry scalp
- ❑ Skin eruptions, rashes
- ❑ Cysts, tumors
- ❑ Ear infections
- ❑ Sore throat, tonsillitis
- ❑ Lymphatic swelling
- ❑ Hot palms and soles
- ❑ Heart palpitations
- ❑ Aversion to heat
- ❑ Bitter taste in mouth
- ❑ Gum problems
- ❑ Nose bleeds
- ❑ Facial redness
- ❑ Itching/burning skin
- ❑ Hot hands/feet
- ❑ Thirst
- ❑ Vivid dreams
- ❑ Dark Urine
- ❑ Night sweats

EARTH ELEMENT

- ❑ Indigestion
- ❑ Flatulence
- ❑ Food allergy
- ❑ Stomach ache/ulcer
- ❑ Diarrhea
- ❑ Anemia
- ❑ Halitosis
- ❑ Sores in mouth
- ❑ Strong appetite
- ❑ Weak Appetite
- ❑ Nausea
- ❑ Abdominal bloating
- ❑ Low body weight

METAL ELEMENT

- ❑ Bronchitis
- ❑ Asthma
- ❑ Shallow breathing
- ❑ Cough
- ❑ Sinus congestion
- ❑ Nasal infections

FEMALE

- ❑ Painful menstrual periods
- ❑ Excessive flow
- ❑ Hot Flashes
- ❑ Irregular cycle
- ❑ Cramps or backaches
- ❑ Previous miscarriage
- ❑ Vaginal discharge
- ❑ Congested breast
- ❑ Breast Pain
- ❑ Lumps in breast
- ❑ Menopausal symptoms
- ❑ Abnormal bleeding
- ❑ Pregnancy
- ❑ Pregnancy complications

MALE

- ❑ Pain associated with genitals
- ❑ Reduced sexual energy
- ❑ Premature ejaculation
- ❑ Seminal emission
- ❑ Impotence
- ❑ Discharges

OTHER

- ❑ Fatigue
- ❑ Sciatica/nerve pain
- ❑ Cold hands/feet
- ❑ Tendonitis
- ❑ Bursitis

Additional Information

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CONSENT TO TREATMENT FORM

By signing below, I do hereby voluntarily consent to be treated with acupuncture and or/Traditional Chinese Medicine by acupuncturist Shannon Gyles.

Acupuncture/Moxabustion: I understand that acupuncture is performed by the insertion of sterile needles through the skin or by the application of heat to the skin (or both) at certain acupuncture points on or near the surface of the body in attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop receiving treatment at any time.

Chinese Herbal Therapy: I understand that substances from traditional Chinese Herbal Therapy may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administering dosage id I do decide to take them. I am aware that certain adverse side effects can result from taking these substances. These could include but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing before treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call New Moon Wellness as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-ma massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. They could include, but are not limited to: bruising, sore muscles or aches, pain or discomfort, and the possible aggravation of the symptoms existing prior to treatment. I understand I may refuse treatment.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse treatment.

Privacy Policy

The information received and collected about our clients/patients from their visit to New Moon Wellness is strictly private and confidential. It is used and viewed only by the healthcare professionals associated NMW, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of NMW. NMW will not give share or transfer any person information to a third party unless required by law. Under absolutely no circumstances will this communication happen without the signed consent of the client/patient. **Please notify us if you would like to receive a copy of our privacy Policy.**

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I also understand that my treatment cannot be used as a substitute for Western medical care.

I have carefully read all the above information and am fully aware of what I am signing. I understand that I may ask Shannon Gyles for additional information before signing this consent form.

I ___________________________________ have carefully read all the above information and am fully aware of what I am signing. I give my permission and consent to treatment.

Please sign name __________________________ Date ________________

Signature witnessed by ___________________________ Date________________

Parent signature ______________________________ Date __________________