MAPLEBROOK ACUPUNCTURE CLINIC

6703 E 81st Street Suite J
Tulsa, OK 74133
(918) 814-7650

CONFIDENTIAL

PATIENT INFORMATION	CONTACT INFORMATION
Date: _____	Home phone: _____
Name: _____	Work Phone: _____
Address: _____	Other/Cell Phone: _____
City, State, Zip: _____	*Do you authorize Maplebrook Acupuncture Clinic to contact via text message? Yes/No"*
DOB: _____	Email: _____
Occupation: _____	Marital Status: _____
Primary Physician: _____	Emergency Contact: _____
Physician phone number: _____	Phone number: _____
Have you received acupuncture therapy before?	Who Referred You: _____

WOMEN'S FERTILITY HISTORY

Age when menses began. _____

Have your cycles changed since they began? YES/NO

If yes, how? _____

Are your periods painful? YES/NO

What color is the blood? _____

Do you have premenstrual tension? YES/NO

Does your face break out before or during your period? YES/NO

Is your menstrual cycle spaced irregularly? YES/NO

Date last menstrual cycle began_____

Have you ever had an abnormal pap smear? YES/NO

How many pregnancies have you had (#, year)?

_____

How many children do you have?

_____

How many miscarriages have you had?

_____

Have you ever had a cervical biopsy, operation, cauterization or conization? YES/NO

Do you get yeast infections regularly? YES/NO

Have you ever had pelvic inflammatory disease? YES/NO

If YES, how were you treated for it? _____

_____

Date of last pap smear_____

Have you ever been diagnosed with uterine fibroids or polyps? YES/NO

Have you been diagnosed with endometriosis? YES/NO

Have you ever been diagnosed with adhesions? YES/NO

Have you ever been diagnosed with any pelvic abnormalities? YES/NO

Have you ever taken oral contraceptives? YES/NO

When? _____ How long? _____

Have you ever taken Depo-Provera? YES/NO

When? _____ How long? _____

Other than contraceptives? _____

_____

WOMEN'S FERTILITY HISTORY

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How long have you been trying to conceive? _____

Have you had a diagnosis relating to fertility? YES/NO

If yes, what was it? _____

Have you had fertility treatments? YES/NO

If yes, when? _____

Where? _____

By whom? _____

What types? _____

Have you taken medication to help you ovulate? YES/NO

If yes, what? _____

When? _____

How long? _____

Have your fallopian tubes been medically evaluated? YES/NO

If yes, what were the results? _____

Have you had any tubal operations? YES/NO

Have you had any hormone lab tests performed? YES/NO

If yes, what were the results? _____

_____

Have you been exposed to any known environmental toxins or hormones? YES/NO

Are you currently taking steroids? YES/NO

Do you have a single partner with whom you have been trying to conceive? YES/NO

Has he had a fertility workup? YES/NO

If yes, what were the results? _____

Is your partner supportive of your wish to conceive? YES/NO

Do you have a stressful occupation? YES/NO

Do you exercise regularly? YES/NO

Do you drink coffee, tea, or sodas? YES/NO

If yes, how much? _____

Do you smoke? YES/NO

Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

5 ELEMENT CHART

INDICATE WITH a **1** any condition that you **sometimes** experience.
2 for those which **occur often.** **3** for symptoms that are a **major concern**.

Water Element	Wood Element	Fire Element	Metal Element	Earth Element
__ Hearing loss	__ Headaches	__ Dry Scalp	__ Bronchitis	__Underweight
__ Dizziness	__ Migraines	__ Skin rash	__ Asthma	__ Indigestion
__ Low back Pain	__Ringing in ears	__ Cysts/tumor	__ Weak breath	__ Flatulence
__ Neck Pain	__ Poor eyesight	__ Ear infection	__ Cough	__ Food allergy
__ Sinus congestion	__Eye infection	__ Sore throat	__ Sinus problem	__ Stomachache
__ Edema	__ Dry eyes	__ Lymph swelling	__ Allergies	__ Ulcer
__ Dark under eyes	__ Eczema	__ Hot palms/soles	__ Nose infection	__ Diarrhea
__ Emotional instability	__ Shingles	__ Heart palpitations	__ Grief/Weeping	__ Anemia
__ Aversion to cold	__Herpes simplex	__ Aversion to heat	__ Skin problems	__ Halitosis
__ Hair thinning/loss	__ Warts	__ Bitter taste in mouth	__ Lost someone	__ Mouth sores
__ Premature aging	__ Nervousness	__ Gum problems		__ Heartburn
__Frequent urination	__Convulsion	__ Nosebleed		__ Big appetite
__ Kidney stones	__ Spasms	__ Facial redness		__ Weak appetite
__ Perspire easily	__ Irritability	__ Itch/burn skin		__ Abd. Bloating
__ Weak legs/knees	__ Constipation	__ Thirst		__ Excess worry
__ Asthmatic cough	__ Hemorrhoids	__ Vivid dreaming		__ Obsessive
__ Rapid weight change	__ Hepatitis	__ Dark urine		__ Acid reflux
	__ Ulcer			
	__ Anger			
	__ Depression			
__ Loose teeth/loss	__ Frustration	__ Night sweats		__ Overthinking
__Reduced sexual energy	__ Vomiting	__ Excess Joy	**Other**	__ Worry
__ Thyroid problems	__Gallstones	__ Joy	__ Fatigue	__ Butterflies in Stomach
__ Diabetes	__ Indecisive	__ Sadness	__ Arthritis	
__ Excess fear	__ Fullness below ribs	__ Crying	__ Sciatica	
__Hearing problems	__ Shoulder tension		__ Nerve pain	
__ Fear	__ Neck tension		__ Cold hands/feet	
__Shock	__ Insomnia 11pm-3am		__Bursitis/tendonitis	