Leslie Oldershaw, L.Ac. & Associates
Acupuncture, Nutrition, & Herbal Medicine
www.leslieoldershaw.com
Ph. 510-595-1175
Fx. 510-595-1190
1331 Grand Avenue
Piedmont, CA 94610

Welcome to Our Practice

Thank you for choosing our office to meet your health care needs. In addition to acupuncture, you will have access to nutritional counseling, herbal medicine, lifestyle counseling, and a broad array of diagnostic testing. Our goal is to provide a safe, healing environment and to support you in your pursuit of optimal well-being.

Your initial visit will take up to two hours. Please plan your schedule accordingly. We will do a thorough health interview and history, and then partner with you to develop a personalized treatment plan. You will have ample time to ask any questions you may have.

Please note that because this time has been reserved especially for you, we request notification of any scheduling changes a minimum of two business days prior to the first appointment, and one business day prior to established patient visits. Any missed appointments are billed at the regular appointment rate.

Directions to our office are in this packet.

To help us better serve you, please take some time to complete and sign the enclosed forms before arriving at your first appointment. If you have recent laboratory test results that you would like to review at the initial appointment, please bring copies, or make arrangements to have them faxed to our office.

If you have any questions, feel free to call us.

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New Patient Fertility Packet

This packet contains everything you need to get started, including information about our practice, our policies, directions to the office, and new patient forms.

The forms in this packet are for those coming in for a fertility evaluation. Along with your health history, there is a place for you to record your fertility history, and relevant lab results. These forms are comprehensive, so please allow some time to fill them out prior to your initial visit.

A note on labs - in our practice we make use of a comprehensive set of lab tests to evaluate your health and fertility. We can order any labs that you might need. Please bring any previous lab results that you would like us to review with you to your initial appointment, or make arrangements to have them faxed to our office.

We look forward to meeting you soon.

Leslie Oldershaw, L. Ac. & Associates

About Our Services

We specialize in offering a comprehensive, highly integrated approach to health and wellness, utilizing the best that both Eastern and Western medicine has to offer. We begin with a thorough assessment, then create an integrated treatment strategy designed to bring about effective results. Our practice focuses on fertility, working with both women and men to correct hormone imbalances, reduce stress, lose weight, and improve energy. We work with fertility patients across the full spectrum of low tech to high tech methods of conception, from those trying to conceive on their own, to patients using assisted reproductive technologies such as IVF (in vitro fertilization). A large percentage of our patients are concurrently undergoing Western fertility treatments, and we have a good working relationship with the reproductive endocrinologists in the area.

We offer our patients a wide variety of modalities to meet their health care needs:

- Acupuncture
- Herbal Medicine
- Nutritional Counseling & Support
- Lifestyle Counseling
- Stress Management
- First Line Therapy
- Neuro-Emotional Technique
- Diagnostic Testing

Please note: These modalities are described in detail on the “Services” page of our website.

About Leslie

Leslie Oldershaw is a licensed acupuncturist, nutritionist, and herbalist providing comprehensive care integrating Eastern and Western medicine to best serve the needs of her patients. Having studied health and nutrition for over 30 years, Leslie earned her Bachelor of Science degree in 1987 from the University of California at Berkeley, and her Master's degree in 1993 from the American College of Traditional Chinese Medicine in San Francisco, with advanced training in women's health and fertility. Leslie is nationally board certified in acupuncture and licensed as a primary care provider by the State of California.

As an undergraduate completing a pre-med curriculum, Leslie's academic focus was on a combination of biochemistry and ecosystems, thus cultivating an appreciation for the interactions that comprise a healthy, highly functional and dynamic living system. This foundation readily supported her study of the holistic paradigm of traditional Chinese medicine. Bringing the best of both worlds together for her patients, Leslie offers a blend of integrative medicine that consists of the holistic infrastructure offered by traditional Chinese medicine combined with modern Western medical science.

Leslie's long-standing interest in women's health and endocrinology led her to specialize in fertility; she has since developed a solid reputation in the Bay Area for helping patients integrate acupuncture, nutrition, stress reduction, lifestyle counseling, and herbal remedies along with Western fertility treatments to achieve optimal fertility.

A prolific writer and engaging public speaker, Leslie's passion for teaching has inspired numerous articles on the subjects of acupuncture, women's health, and fertility, and she frequently lectures on these subjects. Leslie maintains a private practice in Piedmont, California, and directs the program for acupuncture services at the East Bay Fertility Center in Dublin, California.

Office Policies and Procedures

Initial Appointments:

- Please allow up to two hours for your initial visit.
- Please arrive 10 minutes early, with your forms completed.
- Any scheduling changes for initial appointments must be made at least 2 business days in advance. Initial appointments that are missed or rescheduled within 2 business days will be charged at the full visit rate.

Cancellations and Changes:

- If you need to reschedule an appointment, please notify us a minimum of 1 business day prior to your scheduled time, so we have time to schedule someone else that is waiting for an appointment slot.
- If your appointment is on Monday, please notify our office of changes or cancellations no later than noon on the previous Friday.
- Patients who miss their appointment or cancel less than 1 business day prior to their appointment will be required to pay for the missed visit. Missed appointments will be billed to credit card on file.
- Please be respectful to patients on the waiting list, and kindly give us as much advance notice as possible if you need to reschedule.

Your Visits:

- We value our patients' time. In order to keep on schedule, we request that you arrive on time for your appointments. If you arrive more than 10 minutes late for your appointment, it does not allow the necessary time to effectively conduct a treatment and we will need to reschedule you, and will treat it as a missed appointment. We will make every effort to reschedule you ASAP, and if at all possible we will work you into our schedule for that day, contingent on space availability. Please allow sufficient travel time and take traffic conditions into consideration.
- There are occasions where extenuating circumstances arise and we may be delayed for a brief time. This will not affect the length of your visit. Please accept our apologies for any inconvenience.
- Please allow enough time for your complete visit. If you know you need to leave our office by a specific time, please let us know when you first arrive and we will do our best to accommodate you.

Herbs, Supplements & Prescriptions:

- If for any reason you are unable to take your prescribed items as directed or have questions about their use, please let our office know as soon as possible.
- Unopened bottles in resalable condition can be returned for office credit within 30 days of purchase.
- The following items cannot be returned: refrigerated items, special order items, custom formulas.

Payment:

- Payment is due at the time of your appointment, unless alternate arrangements have been made.
- Accepted methods of payment are: **Visa, MasterCard, Check and Cash.**
- We require all patients to have a current signed credit card authorization form on file to secure your appointments and fulfill your mail-order prescriptions.

Insurance:

In order to help control your health care costs, our office does not directly bill insurance companies. A "Superbill" receipt (form detailing diagnostic codes and fees) can be provided to you for each visit. This receipt can be submitted to your insurance carrier. Based on the terms of your policy, you will be reimbursed directly by your insurance carrier. If you have a healthcare savings account or flexible spending plan, we'll be glad to provide you with documentation for your expenditures that you can submit for reimbursement.

Directions

We are located at 1331 Grand Ave. in Piedmont near the corner of Grand Ave. and Sunnyside. If you are traveling up Grand Ave. from Oakland, the numbers will change as you cross over the city line (at the ACE Hardware). The numbers coming from the 580 freeway will be in the 3000s in Oakland, and then drop to the 1200s in Piedmont. Our building is a medical duplex with “Dental by Design” in the front. Our office is in the back and can be reached either from Grand Ave. or from the rear via a driveway off Sunnyside. To enter from Grand Ave., go up the front stairs and walk back past the dental office on the right. You can also enter from the driveway off Sunnyside at the back of the building by following the path around the right side to our door. This back entrance is flat, with no stairs.

From Berkeley and North:

Take I80 West to 580 East. Exit at Grand Ave. Turn left and go under the freeway. Continue up Grand Ave. for 8-10 blocks. We’re on the left, just past the Ace Hardware, and across from the Kehilla Community Synagogue.

From Oakland and South on 580:

Take 580 West to Grand Ave. Exit and turn left at the light. Continue up Grand Ave. for 8-10 blocks. We’re on the left, just past the Ace Hardware, and across from the Kehilla Community Synagogue.

From Oakland and South on 880:

Go north on 880 to Oakland. Take 980 to 580 East. Exit at Grand Ave. Turn left at the light and continue up Grand Ave. for 8-10 blocks. We’re on the left, just past the Ace Hardware, and across from the Kehilla Community Synagogue.

From Orinda & East:

Take Hwy 24 West to the Broadway exit. Take Broadway down towards Oakland, and at the first huge intersection turn left onto Pleasant Valley. Follow Pleasant Valley across Piedmont Ave., and as it winds around it becomes Grand Ave. Look for a stoplight at Oakland Ave., and continue three more blocks. We are on the right.

From San Francisco:

Cross the Bay Bridge on I-80 East. Once across the bridge follow signs to 580 East, towards Hayward. Continue on 580 East and exit at Grand Ave. Turn left at the light and continue up Grand Ave. for 8-10 blocks. We’re on the left, just past the ACE Hardware.

Parking

- ❑ There is parking on Grand Avenue as well as on Sunnyside. All street parking is meter free!!

- ❑ Please do not park in the synagogue parking lot across the street.

- ❑ The parking lot under the building is reserved for staff only during the day. You may park here any day after 5:00 pm, and all day on Fridays, Saturdays, and Sundays.

- ❑ There is a blue handicap spot in the back of the building. Access is from Sunnyside. Please note that if you use the spot, you must back all the way out of the driveway and back onto Sunnyside.

- ❑ If you have any difficulty climbing stairs, please know that there are two flights of stairs coming in from the front of the building and Grand Avenue. However, if you are able to park on Sunnyside near our driveway, there are no stairs at the back of our building. If you are concerned about access, please call us and we can give you information regarding the official handicap space. If you don't have a Handicap placard, we can make arrangements for an additional space that provides easy access to our front door.

Patient Information

Today's date: ______________

Name: ____Birth date: ______________Age: _______

Preferred name: __________________ Gender: _________Place of birth: _________________________

Marital status: ___________________________________Number of children: ___________________

Occupation: _____________________________________Employer: _________________________

Please see the Patient Authorization sheet for mailing address, email, and phone numbers.

Emergency contact:

Name: ____________________________________Phone: __________________Relationship: ________

How did you hear about our clinic: ____

May we send a thank you card: Yes No

Primary treating physician: _____________________________________ Phone: ___________________

OB/Gyn: ____ Phone: ___________________

Reproductive endocrinologist: __________________________________ Phone: ___________________

Other specialist: ____ Phone: ___________________

Other specialist: ____ Phone: ___________________

Other specialist: ____ Phone: ___________________

Have you ever been treated with acupuncture? Yes No

If yes, condition treated? ____

Patient Authorization for Appointment Reminders, Scheduling-Related Matters, Related Health Services, and/or Related Health Products

It is our desire for our staff to use your name, address, e-mail address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments or other appointment-related issues. We would also like to advise you about health-related meetings, workshops, and products.

The use of this information is intended to make your experience with our office more efficient, productive and enhance your access to quality health care. If you choose not to authorize this information use, your decision will have no adverse effect on your care from Leslie Oldershaw, L.Ac., or on your relationship with our staff.

____
Mailing address

____
City State Zip

____
E-Mail address

Please indicate which number to use for:		Messages	Don't Call
Home Telephone:	______________________	☐	☐
Work Telephone:	______________________	☐	☐
Cell Telephone:	______________________	☐	☐
E-mail Address:	______________________	☐	☐
Would you like to be on our mailing list?		Y	N
Would you like to receive e-mail newsletters?		Y	N

Your signature indicates your authorization of this activity.

____
Name (Printed) Signature Date

You may revoke this authorization at any time. Please advise us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Credit Card Authorization

We require a current credit card number on file to secure your appointments and for any mailed prescriptions or special orders. We will never charge this number without giving you prior notice.

I, (print name)____ authorize

Leslie Oldershaw & Associates, 1331 Grand Ave., Piedmont, CA 94610
to bill my credit card as listed below:

Name on Credit Card ____

Credit Card Details

Circle one: Visa MasterCard

Card # : ____

Expiration Date: ____

CVS code (3 digit security code on back of card)**:** ___________________

Billing Address

Address: ____

City: ________________________ **State:** _________ **Zip:**_____________

Phone (include area code)**:** _____________________________________

AUTHORIZATION

X____
Cardholder's signature Today's date

This authorization can be revoked upon your written notice to our office.

Informed Consent to Care and Treatment

I hereby request and consent to the performance of acupuncture treatments and other Eastern Medicine procedures, including various physical modalities, on me (or on the patient named below, for whom I am legally responsible) by licensed acupuncturists who now or in the future treat me while employed by or associated with or serving as back-up in the offices of Leslie Oldershaw and Associates.

I understand that methods of treatment may include, but are not limited to, acupuncture, infrared therapy, electrical stimulation, massage, herbal medicine and nutritional counseling. I have had the opportunity to discuss with the treating physician or other clinic personnel the nature and purpose of acupuncture treatments and other procedures.

I have been informed that acupuncture is a generally safe method of treatment, but as with all medical procedures, it may have some side effects, including bruising, numbness or tingling near the needle sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this office uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Eastern medicine, although some may be toxic in large doses. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of herbs or nutritional supplements. I understand that some herbs or supplements may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of the treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interests. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent to care and treatment. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient name (printed)	Patient signature	Date
Patient's representative (printed)	Representative's signature	Relationship

Health History

Name: ____ Today's Date: ____________________

Reason for visit: Please list your 5 major health concerns in order of importance:

1. ____

2. ____

3. ____

4. ____

5. ____

Major hospitalizations, surgeries, illnesses, injuries:

Year	Surgery, illness, injury	Outcome
__________	____	______________________________
__________	____	______________________________
__________	____	______________________________
__________	____	______________________________
__________	____	______________________________

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 19

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems):

____

____

Height: ___________________ Weight: __________________ BMI: ________________

Do you consider yourself: Under-weight Over-weight Just right

Have you experienced unexpected weight gain or weight loss of greater than 10 pounds in the last three months?

Yes No If yes, how much? ________________

Do you smoke? Yes No If yes, how much per day? __________ Per week? ______________

Medical History

Please check any current or past conditions.

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol elevated
- ❑ Circulatory problems
- ❑ Cloudy thinking
- ❑ Colitis
- ❑ Constipation
- ❑ Debilitating fatigue
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diarrhea, chronic
- ❑ Diverticulitis
- ❑ Dizziness, chronic
- ❑ Drug use
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastric reflux
- ❑ Genetic disorder
- ❑ Gout
- ❑ Headaches, migraines
- ❑ Headaches, stress
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Insomnia, chronic
- ❑ Irritable bowel disease
- ❑ Kidney or bladder disease
- ❑ Liver or gallbladder disease (stones)
- ❑ Nausea, chronic
- ❑ Vomiting, chronic
- ❑ Neurological problems
- ❑ Panic attacks
- ❑ Pain, chronic
- ❑ Shortness of breath
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Seasonal affect disorder
- ❑ Skin problems
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins
- ❑ Other

____

____

Family Health History (Parents & Siblings):

- ❑ Arthritis
- ❑ Asthma
- ❑ Autoimmune conditions
- ❑ Cancer
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Heart disease
- ❑ Obesity
- ❑ Stroke
- ❑ Other

Exercise:

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk
- ❑ Run, jog, or jump rope
- ❑ Weight lift
- ❑ Swim
- ❑ Cycle
- ❑ Yoga
- ❑ Other

____

Nutrition and Diet:

- ❑ Omnivore (animal & vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Processed foods
- ❑ Whole foods
- ❑ Specific food restrictions:
  - ❑ Dairy
  - ❑ Wheat
  - ❑ Eggs
  - ❑ Soy
  - ❑ All Gluten
  - ❑ Other

____

Food Frequency

How many servings per day?

_____Fruits
_____Vegetables
_____Grains
_____Beans and peas
_____Nuts and seeds
_____Dairy
_____Eggs
_____Meat
_____Poultry
_____Fish

Eating Habits:

- ❑ Skip breakfast
- ❑ Eat three meals/day
- ❑ Eat two meals/day
- ❑ Eat one meal/day
- ❑ Graze (small frequent meals)
- ❑ Eat constantly whether hungry or not
- ❑ Generally eat on the run
- ❑ How many times do you eat out per week?

  ____
- ❑ How many alcoholic beverages do you consume in a week?

  ____
- ❑ How many caffeinated beverages do you consume per day?

  ____

Would You Like To:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve your complexion
- ❑ Have stronger nails
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Not be dependent on over the counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath
- ❑ Have agreeable body odor
- ❑ Have stronger teeth
- ❑ Get less colds and flues
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (i.e. cancer, heart disease, etc.)

Gynecological Herstory

Please check any current or past conditions.

- ❑ Abdominal bloating
- ❑ Abdominal pain
- ❑ Acne
- ❑ Anemia
- ❑ Birth control pills
- ❑ Breast distention
- ❑ Breast pain
- ❑ Cancer
- ❑ Constipation
- ❑ Depression
- ❑ Dry skin
- ❑ Endometriosis
- ❑ Excessive facial hair
- ❑ Excessive body hair
- ❑ Fatigue
- ❑ Fibroids
- ❑ Fibrocystic breasts
- ❑ Frequent urination
- ❑ Hair loss
- ❑ Headaches
- ❑ Hemorrhoids
- ❑ Hot flashes
- ❑ HRT
- ❑ Infertility treatments
- ❑ Irregular periods
- ❑ Irritability
- ❑ Itchy skin
- ❑ IUD
- ❑ Low back pain
- ❑ Menopause, age___________
- ❑ Mood swings
- ❑ Night sweats
- ❑ Pain at ovulation
- ❑ Pain with intercourse
- ❑ Pelvic inflammatory disease
- ❑ Pelvic pain
- ❑ Pelvic surgery
  - Date: ____________________
  - Date: ____________________
  - Date: ____________________
- ❑ Perimenopause
- ❑ Polycystic ovarian syndrome (PCOS)
- ❑ Polyps
- ❑ PMS
- ❑ Spotting
- ❑ STDs
- ❑ Thyroid issues
- ❑ Urinary tract infections
- ❑ Vaginal dryness
- ❑ Water retention
- ❑ Yeast infections
- ❑ Number of pregnancies: ___________________
- ❑ Number of children: ___________________

Menses

- ❑ Age you started having periods_____________________
- ❑ # Days of flow_______________
- ❑ # Days from first day of cycle to the next first day_________________________
- ❑ First day of your last period? ____________________________

Please check that which best describes your average menses:

- ❑ Amount of blood
  - ❑ Light
  - ❑ Medium
  - ❑ Heavy
- ❑ Color of blood
  - ❑ Pale
  - ❑ Medium red
  - ❑ Dark
  - ❑ Brown
- ❑ Clots
  - ❑ Small
  - ❑ Large
  - ❑ A few
  - ❑ Many
- ❑ Cramps
  - ❑ Mild
  - ❑ Moderate
  - ❑ Severe
  - ❑ Before bleeding
  - ❑ With bleeding
  - ❑ Cramps last 1 day
  - ❑ Cramps last 2 days
  - ❑ Cramps last more than 2 days
  - ❑ Pain meds

Women's Fertility Herstory

How long have you been trying to conceive?____

Have you had a diagnosis of fertility? Yes No

If yes, what was it?____

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

Name of partner:_____________________________ gender:______DOB:________Age:______

Is your partner supportive of your wish to conceive? Yes No

How long have you been together?_______How long have you had unprotected sex?_________

Please list your fertility treatments, preferably in chronological order:

Date	what	doctor	outcome

Please list your pregnancies, and the outcome:

Year	Miscarriage?	Ectopic?	Abortion?	Live birth?	How long to conceive?	Fertility treatments used for conception?	Is current partner the father?

Men's Fertility History

Name:___________________________________DOB:__________Age:_____

Partner:__________________________________DOB:__________Age:_____

How long have you been trying to conceive:____________________________

How many children have you fathered?________________________________

Please list the years:____

Have you experienced any difficulty maintaining an erection? Yes No

Have you experienced a decrease in morning erections? Yes No

Have you experienced difficulty ejaculating? Yes No

Have you experienced any penile discharge? Yes No

Have you experienced any difficulty urinating? Yes No

Do you have undescended testes? Yes No

Have you ever been diagnosed with an STD? Yes No

Have you ever been diagnosed with a varicocele? Yes No

Have you had any urological surgeries? Yes No

Have you had a vasectomy? Yes No

Have you had a vasectomy reversal? Yes No

Have you been exposed to any known environmental toxins? Yes No

Have you had a fertility work-up that includes testosterone levels? Yes No

Have you had a semen analysis? Yes No

If yes:

What was your sperm count? Normal Low

What was your sperm motility? Normal Low

What was your volume? Normal Low

Anything else you'd like me to know:

____

____

____

Medications & Supplements

Please list any known allergies:

____

____

____

Please list all current medications that you are taking:

Start date:	Item:	Amount:	Frequency:

Please list all current vitamin supplements and herbs that you are taking:

Start date:	Item:	Amount:	Frequency:

Metabolic Assessment Form

Please circle: 0 - "never"; 1 - "occasionally"; 2 - "frequently"; 3 - "almost always"

Category 1: Colon

Feeling that bowels don't empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard dry or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amounts of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Frequent use of laxatives	0	1	2	3

Category 2: Hypochlorhydria

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables	0	1	2	3
Undigested foods seen in stool	0	1	2	3

Category 3: Hyperacidity (Ulcer)

Stomach pain, burning, or aching 1 - 4 hours after eating	0	1	2	3
Frequent use of antacids	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn w/ lying down/bending forward	0	1	2	3
Temporary relief from antacids, food, milk	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, citrus, peppers, alcohol, and/or caffeine	0	1	2	3

Category 4: Small Intestine (Pancreas)

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2 - 4 hours after eating	0	1	2	3
Pain, tenderness, soreness, left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stools loose, foul smelling, mucousy	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category 5: Biliary Insufficiency/Stasis

Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter or metallic taste in mouth	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to the eyes	0	1	2	3
Stool color alternates from light to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gall bladder removed?		Yes		No

Category 6: Hypoglycemia

Eating relieves fatigue	0	1	2	3
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to get started or keep yourself going	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Feel shaky, jittery	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category 7: Insulin Resistance

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets doesn't relieve sugar cravings	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth equal to or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category 8: Adrenal Hypofunction

Cannot stay asleep	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3
Crave salt	0	1	2	3

Category 9: Adrenal Hyperfunction

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even with plenty of sleep	0	1	2	3
Excessive perspiration	0	1	2	3
Perspiration with little or no activity	0	1	2	3

Category 10: Hypothyroid

Tired, sluggish	0	1	2	3
Feel cold - hands, feet, all over	0	1	2	3
Require excess sleep to function properly	0	1	2	3
Increase in weight gain even w/ lo-cal diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that taper off	0	1	2	3
Thinning of the outer third of eyebrow	0	1	2	3
Thinning of hair on scalp, face, or genitals	0	1	2	3
Hair falling out excessively	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category 11: Thyroid Hyperfunction

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category 12: Pituitary Hypofunction

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menses	0	1	2	3
Increased ability to eat sugars w/o symptoms	0	1	2	3

Category 13: Pituitary Hyperfunction

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" headaches	0	1	2	3

Category 14 (Males Only): Prostate

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg(s) "restless" at night	0	1	2	3

Category 15 (Males Only): Andropause

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increased fat distribution at chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in past	0	1	2	3

Category 16(Menstruating Females Only):

Are you menopausal?		Yes		No
Alternating lengths of menstrual cycles		Yes		No
Extended cycle, greater than 32 days		Yes		No
Shortened cycle, less than 24 days		Yes		No
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category 17 (Menopausal Females Only):

How many years since your last menses?	___________			
Any uterine bleeding post menopause?		Yes		No
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Vaginal pain	0	1	2	3
Vaginal dryness	0	1	2	3
Vaginal itching	0	1	2	3

Previous infertility evaluation:

Please fill in any test results that you have previously completed:

Date	Result	Lab Tests	
		Hormones:	
		CD 3 FSH	Cycle day 3 follicle stimulating hormone
		CD 3 E2	Cycle day 3 estradiol
		CCT	Clomid challenge test
		CD 3 LH	Cycle day 3 lutenizing hormone
		PROL	Prolactin
		P4	Progesterone, 7 days after ovulation
		TSH	Thyroid stimulating hormone
		Total T4	Thyroid hormone- total T4
		Free T4	Thyroid hormone - free T4
		Free T3	Thyroid hormone - free T3
		Free TT	Free testosterone
		Cortisol	
		DHEA-S	
		ABO +/-	Blood type with Rh factor
		CBC w/diff:	Complete blood count with differential
		Hgb	Hemoglobin
		Hct	Hematocrit
		Lipids:	
		Total cholesterol	
		Triglycerides	
		LDL	Lousy cholesterol (aka low density lipoproteins)
		HDL	Healthy cholesterol (aka high density lipoproteins)
		Total/HDL	Total cholesterol to HDL ratio
		Blood sugars:	
		Fasting glucose	
		LDH	Lactate dehydrogenase
		A1C	Glycosolated hemoglobin A1c
		GTT	Glucose tolerance test
		MTHFR	MTHFR gene- needed for folic acid metabolism
		Structure:	
		HSG	Hysterosalpingogram
		AFC	Antral follicle count
		EML	Endometrial lining
		Immunology:	
		TPO Ab	Thyroid antibodies (thyroid peroxidase)
		TG Ab	Thyroid antibodies (thyroglobulin)
		ANA	Antinuclear antibodies
		APA	Antiphospholipid antibodies
		Natural Killer cell assay	
		Antisperm antibodies	
		DQ Alpha	
		Semen analysis	