

Patient Information

CONFIDENTIAL

Acupuncture and Oriental Medicine- Sylvia Salcedo Rojas L.Ac
*700 East 9th Ave, Suite 105 Denver CO 80203 Phone: 303- 832- 7375

Welcome to the Acupuncture and Oriental Medicine Clinic

Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. The Acupuncture and Oriental Medicine Clinic considers this information privileged physician/patient communication and will hold it in confidence.

NAME (LAST, FIRST, MIDDLE)	DATE
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AGE	DATE OF BIRTH	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	Would you like to be placed on our mailing list to receive our newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>Your information is for our private use only</small>
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PHONE	EMAIL ADDRESS
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HOME ADDRESS		
CITY	STATE	ZIP CODE

OCCUPATION	
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EMPLOYED BY

CONTACT IN CASE OF AN EMERGENCY	RELATIONSHIP	PHONE
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REFERRED BY:

The diagnosis and treatment plan I will be given by the Acupuncture and Oriental Medicine Clinic is based upon Traditional Chinese medical principles and does not constitute a western medical diagnosis. I understand that I should be evaluated by a physician for the condition I am requesting consultation. Further, if I am concurrently undergoing western medical treatments, it is my responsibility to advise my physician of any herbal supplements I am taking.

SIGNATURE

DATE

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PRIMARY ISSUE

1. Age at which menses began? _____
2. Are your periods painful? YES NO
 - a. Are they painful before period starts? YES NO
 - b. Are they painful on the first day of bleeding? YES NO
3. How many days do you normally bleed?
4. How heavy is the bleeding? YES NO
5. What color is the blood? Pale Red Bright Red Purple/dark red
6. Is there clotting? YES NO
7. Do you have premenstrual tension? YES NO
8. Does your face break out before or during your period? YES NO
9. Do your breasts become tender premenstrually? YES NO
10. Do you bleed or spot between periods? YES NO
11. Are your menstrual cycles spaced out irregularly? YES NO
12. How many days are there from one period to the next?
13. Date of last menstrual cycle?

Number	Years
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14. How many pregnancies have you had?
15. How many children do you have
16. How many abortions have your had?
17. How many miscarriages have you had?
18. How many D & C have been performed?
19. Have you ever had an abnormal pap smear? YES NO
20. Have you ever had a cervical biopsy, operation, Cauterization, conization? YES NO
21. Have you ever had a venereal disease? YES NO
22. Do you get yeast infections regularly? YES NO
23. Have you ever been diagnosed with a chlamydial infection YES NO
24. Do you have chronic vaginal discharge? YES NO
25. Do you have any sores on your genitalia? YES NO
26. Have you ever had pelvic inflammatory disease? YES NO
 - a. Were you treated for it?
 - b. How?
27. Date of last pap smear?
28. Have you ever been diagnosed with uterine fibroids or polys? YES NO
29. Have you ever been diagnoses with endometriosis? YES NO

30. Have you been diagnosed with pelvic adhesions? YES NO
31. Have you been diagnosed with any pelvic abnormalities? YES NO
32. Have you taken any medication for gynecological conditions other than contraceptives?

Medication	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

33. Have your cycles changed since they began? YES NO
How?
34. Do you ovulate on your own? YES NO
35. On what day of your cycle? YES NO
36. Do your breasts get tender at/during ovulation? YES NO
37. Do you get premenstrual low back pain? YES NO
38. Do your bowel movements become loose at the beginning of you period? YES NO
39. Have you had fertility treatments? YES NO
If yes, when and where?
By whom?
What type?
40. Have you taken medication to help you ovulate? YES NO
When _____ How long? _____
41. Have your fallopian tubes/ uterus been evaluated medically? YES NO
What were the results?
42. Have you had any tubal operations? YES NO
43. Have you had any hormone laboratory test performed? YES NO
What were the results? _____
44. Do you have a single partner with whom you have been trying to conceive? YES NO
45. How long have you been living together?
46. Has he had a fertility work up? YES NO
a. What were the results?
45. Have you taken oral contraceptives? YES NO
When? _____ How long? _____
46. Have you ever had an IUD? YES NO
When? _____ How Long? _____
47. How long have you been trying to conceive?
48. Have you had a diagnosis relating to conceive? YES NO
a. What was it? _____
49. How is your sexual energy?
50. Do you use vaginal lubricants? YES NO
51. Are you more that 20% over your ideal body weight? YES NO

52. Are you more than 20 % below your ideal body weight? YES NO
53. Do you have a stressful occupation? YES NO
54. Do you exercise regularly? YES NO
55. Do you have excessively oily skin? YES NO
56. Have you had excessive loss of head hair? YES NO
57. Do you notice discharge from your nipples? YES NO
58. Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? YES NO
59. Have you been exposed to any known environmental toxins or hormones? YES NO
60. Are you presently taking steroids? YES NO

Circle the numbers in front of the sentences that apply to you

KIDNEY YIN DEFICIENCY

1. Do you have low back weakness, soreness or pain or knee problems
2. Do you have ringing in your ears or dizziness
3. Is your hair prematurely turning grey
4. Do you have vaginal dryness
5. Is your mid cycle fertile cervical mucus scanty or missing
6. DO you have dark circles under or around your eyes
7. Do you have night sweats
8. Are you prone to hot flashes
9. Would you describe yourself as afraid a lot?
10. Does your tongue lack coating? Does it appear shiny or peeled?

KIDNEY YANG DEFICIENCY

1. Do you have low back pain before your period?
2. Is your low back sore or weak?
3. Are your feet cold, especially at night?
4. Are you typically colder than those around you?
5. Is your libido low? Are you often fearful?
6. Do you wake up in the night or early morning because you have to urinate?
7. Do you urinate frequently and is the urine diluted and or profuse?
8. Do you have early morning loose urgent stools
9. Does your menstrual blood tend to be dull in color?
10. Do you feel cold cramps during your period that respond to heating pads
11. Is your tongue pale, moist, and swollen

SPLEEN QI DEFICIENCY

1. Are you often fatigued
2. Do you have a poor appetite?
3. Is your energy low after meals?
4. Do you feel bloated after eating?
5. Do you crave sweets?
6. Do you have loose stools, abdominal pain or digestive problems?
7. Are your hands and feet cold?

8. Is your nose cold?
9. Are you prone to feeling heavy or sluggish?
10. Are you prone to feeling heaviness or grogginess in the head?
11. Do you bruise easily?
12. Do you think you have poor circulation?
13. Do you have varicose veins?
14. Are you lacking strength in your arms and legs
15. Are you lacking exercise?
16. Are you prone to worry?
17. Have you been diagnoses with low blood pressure
18. Do you sweat a lot without exerting yourself?
19. Do you feel dizzy or light headed or have visual changes when you stand up fast?
20. Is your menstruation thin, watery, profuse, or pinkish in color?
21. Are you more tired around ovulation or menstruation?
22. Do you ever spot a few days or more before your period comes?
23. Have you ever been diagnoses with uterine prolapse?
24. Are your menstrual cramps accompanied by a bearing down sensation in your uterus?
25. Are you often sick?
26. Have you been diagnosed with hypothyroid or anemia?
27. Do you have hemorrhoids or polyps?
28. Does your tongue look swollen, with teeth marks on sides
29. Do you have a pale yellowish complexion

BLOOD DEFICIENCY

30. Are your menses scanty and /or late?
31. Do you have dry, flaky skin?
32. Are you prone to getting chapped lips?
33. Are your fingernails or toenails brittle?
34. Are you losing hair on you head (not in patches, but all over)?
35. Is your hair brittle or dry?
36. Do you have diminished nighttime vision?
37. Do you get dizzy or light-headed around your period?
38. Are your lips, the inner of your eyelids, or tongue pale in color?

BLOOD STASIS

39. Is you menstrual flow ever brown or black in color?
40. Do you feel midcycle pain around your ovaries?
41. Do you have painful, unmovable breast lumps?
42. Do you experience periodic numbness of your hands and feet (especially at night)?
43. Do you have varicose or spider veins?
44. Do you have red hemangiomas (cherry-red spots) on your skin
45. Does your complexion appear dark and “sooty”?
46. Do you chronic hemorrhoids?
47. Does your menstrual blood contain clots?
48. Have you been diagnosed with endometriosis or uterine fibroids?
49. Is your lower abdomen tender to palpation (resisting touch)?
50. Can you feel any abdominal lumps in your lower abdomen?
51. Do you have piercing or stabbing menstrual cramps?
52. Does your tongue look dark?

53. Do you have dark spots on your tongue?
54. Do you have dark spots in your eyes?
55. Have you been diagnosed with any vascular abnormality or blood disorders?

LIVER QI STAGNATION

56. Are you prone to emotional depression?
57. Are you prone to anger and/or rage?
58. Do you become irritable premenstrually?
59. Do you feel bloated or irritable around ovulation?
60. Does it feel as if your ovulation lasts longer than it should?
61. Are your breasts sensitive/sore at ovulation?
62. Do you experience nipple pain or discharge from your nipples?
63. Do you have a lot of premenstrual breast distension or pain?
64. Have you been diagnosed with elevated prolactin levels?
65. Do you become bloated premenstrually?
66. Are your pupils usually dilated and large?
67. Do you have difficulty falling asleep at night?
68. Do you experience heartburn or wake up with a bitter taste in your mouth?
69. Are your menses painful?
70. Is your menstrual blood thick and dark, or purplish in color?
71. Is your tongue dark or purplish in color?

HEART DEFICIENCY

72. Do you wake up early in the morning and have trouble getting back to sleep?
73. Do you have heart palpitation, especially when anxious?
74. Do you have nightmares?
75. Do you seem low in spirit or lacking vitality?
76. Are you prone to agitation or extreme restlessness?
77. Do you fidget?
78. Is the tip of your tongue red?
79. Is there a crack in the center of your tongue that extends to the tip?
80. Do you sweat excessively, especially on your chest?

EXCESS HEAT

81. Is your pulse rate rapid?
82. Are your mouth and throat usually dry?
83. Are you thirsty for cold drinks most of the time?
84. Do you often feel warmer than those around you?
85. Do you wake up sweating or have hot flashes?
86. Do you break out with red acne? (esp. premenstrually)
87. Do you have a short menstrual cycle?
88. Do you have vaginal irritation or rashes?

DAMPNESS

89. Do you feel tired and sluggish after a meal?
90. Do you have fibrocystic breasts?
91. Do you have cystic or pustular acne?
92. Do you have urgent, bright, or foul-smelling stools?
93. Does your menstrual blood contain stringy tissue or mucus?

94. Are you prone to yeast infections and vaginal itching

95. Do your joints ache, especially with movement?

96. Are you overweight?

97. Do you have a wet, slimy tongue?

DAMP HEAT

98. Do you have signs of heat and or dampness as indicated above?

99. Do you have foul-smelling, yellow or greenish vaginal discharge?

100. Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase?

COLD UTERUS

101. Does your abdomen feel cooler to the touch than the rest of your trunk?

* questions were gather from The Infertility Cure- Randine Lewis