Angea Fertility Clinic
3/17 Izett Street, Prahran, Victoria 3181
Phone: 03 9510 3700
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Angea Acupuncture & Yoga

Men's Fertility Forms

Date:

Last name /	First name /

Tick: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.

Birth date /	Age /	Preferred # (please tick)
Address /		Phone (home) /
City /		Phone (work) /
Country /	Post Code /	Phone (mobile) /
Email /		Occupation

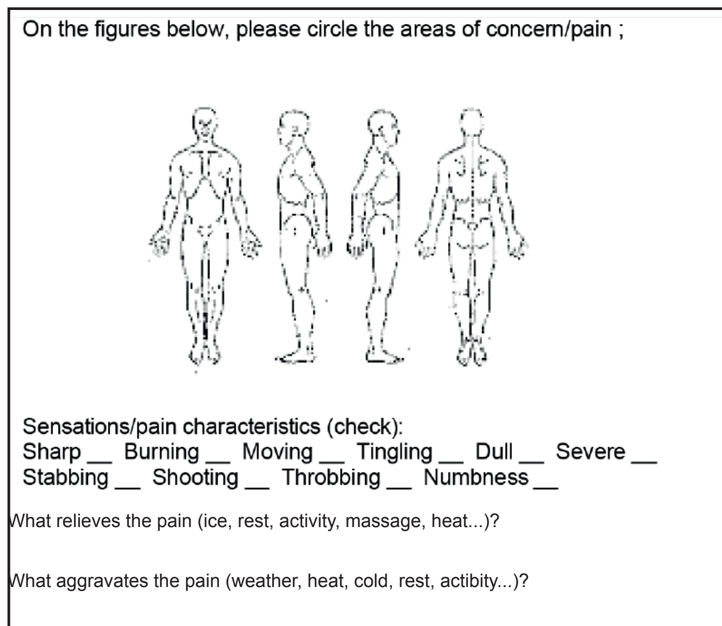
Reason for Visit /

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

Family Physician name /	Family Physician Phone /
Western Medical diagnosis (if applicable) /	
Other medical treatment received (tick) / ☐ Fertility clinic ☐ Physiotherapy ☐ Massage ☐ Naturopathy ☐ Chiropractic ☐ Other:	

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

	Condition		Condition		Condition		Condition
	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 ;

Sensations/pain characteristics (check):
Sharp __ Burning __ Moving __ Tingling __ Dull __ Severe __
Stabbing __ Shooting __ Throbbing __ Numbness __

What relieves the pain (ice, rest, activity, massage, heat...)?

What aggravates the pain (weather, heat, cold, rest, actibity...)?

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 any allergies (food, drugs, environmental etc.):

Have you been hospitalised and/or treated for any infectious/ serious conditions or surgeries? If yes, briefly explain for what condition or reason and the year (below):

Do you use the following? If so, how often? Cigarettes: __________ Alcohol: __________ Drugs: __________ Coffee: __________ Soft Drinks: __________

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 Angea Fertility Clinic? (Internet, Friend, Doctor, Fertility Clinic, Seminar, Magazine, TV, news)

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

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

Gan		Shen		Pi	
____	Irritability / frustration / impatient	____	Frequent urination	____	Heaviness in the head / body
____	Depression	____	Bladder infection	____	Fatigue / after eating
____	Stress	____	Lack of Bladder control	____	Difficult getting up in morning
____	Emotional eating	____	Wake to urinate	____	Water retention
____	Unfulfilled desires	____	Feel cold easily	____	Muscular tired / weak
____	Visual problems / floaters	____	Cold hands / feet	____	Bruise easily
____	Blurred vision / poor night vision	____	Night sweats / hot flushing	____	Unusual bleeding (stool, nose, etc)
____	Red / Dry / Itchy eyes	____	Low sex drive	____	Bad breath
____	Headaches / Migraines	____	High sex drive	____	Poor appetite
____	Dizziness	____	Loss of head hair	____	Increased appetite
____	Feeling of lump in throat	____	Hearing problems	____	Crave sweets
____	Muscle twitching / spasm	____	Crave salty food	____	Poor digestion
____	Neck / shoulder tension	____	Fear	____	Nausea / vomiting
____	Brittle nails	____	Poor long term memory	____	Bloating / gas
____	Sighing	____	Ankle swelling	____	Hemorrhoids
____	Sensation or pain under rib cage	____	Tinnitus	____	Constipation
____	PMS			____	Loose stool
____	Genital itching / pain / rashes			____	Alternate constipation / loose
Xin		**Fei**		____	Abdominal pain
____	Palpitations	____	Dry cough	____	Intestinal pain / cramping
____	Chest pain / tightness	____	Cough with Phlegm	____	Heartburn
____	Insomnia / Sleep problems	____	Nasal discharge / drip	____	Pensive / over-thinking
____	Restless / easily agitated	____	Sinus infection / congestion	____	Overweight
____	Vivid dreams	____	Itchy / painful throat	____	Foggy mind
____	Lack of joy in life	____	Dry mouth / throat / nose	____	Yeast infection
____	Forgetful	____	Skin rashes / hives	____	Aversion to cold
____	Aversion to heat	____	Snoring	____	Cold nose
____	Bitter taste in mouth	____	Grief / sadness	____	Increased Thirst
____	Tongue / mouth ulcers / cankers	____	Shortness of breath	____	Prefer Warm / Cold drinks
		____	Allergies / asthma	____	Sweat easily
		____	Weak immune system		
		____	Alternate fever / chills		

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 best)?

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

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

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

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

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.)

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?

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

Occupation: In the space provided below please explain what you do, duties involved and stress levels.

Personal Stress: In the space provided below please help us understand the personal stresses in your life.

What health related goals would you like to achieve with your treatment at Angea Fertility Clinic?

What do you think is the cause of your fertility issues, and what would fix them?

In the 2nd column, please take some time think critically and be honest. In the 3rd column list the terms or phrases that accurately describe aspects of your character.

Kidney Yang Vacuity	Doing to much, suppressing fears but living in great stress from fear of loss of control, lack of will power, safety byobtaining power, paralyzed by the unknown, take blame, feel guilty, large sense of responsibility, sexual anxiety	
Kidney Yin Vacuity	Lacking energy, fearful, giving up on life and surrendering control of their own destiny, do not do enough, easily discouraged, lacking the determination to achieve goals, forget names. Irritable, fidgety, jumpy, chatty	
Liver Qi Stagnation	Feel stuck, frustrated, hit a wall, blocked, emotional tension,stress, easily annoyed, grumpy, depressed	
Lower Jiao DampHeat	The possibility of transformation becomes the burden of unfinished business, excess worry, feel trapped by many good opportunities, many unfinished projects, procastination, cannot make clear decisions care for others but not se lf	
Heart Spleen Qi and Blood Vacuity	Forgetful, anxiety with situations and people, shyness, feel vulnerable, withdrawing, forget the words you are meaning to say, poor self esteem, forget routine things, poor motivation, lack of excitement, bored, despondent, avoid activities that were once pleasurable, not interested in the world, not engaged in creative transformation	

Name: Name of spouse:

How long have you and your partner been trying to conceive?

Are you currently undergoing assisted reproductive fertility treatments? (IUI, IVF, ICSI, superovulation, etc)

Yes No If yes, at what Clinic

How would you define your sexual energy?	Below normal	Normal
Have you had a recent physical exam? ………………………………………………………	Yes	No
Do you or did you have an undescended testicle? ……………………………………….	Yes	No
Have you ever been diagnosed with a varicocele? ……………………………………….	Yes	No
Have you ever had any urologic surgeries? ………………………………………………..	Yes	No
Have you experienced erectile dysfunction? ………………………………………………...	Yes	No
Have you experienced difficulty ejaculating? ………………………………………………	Yes	No
Have you had exposure to any known environmental toxins or hormones? ……………	Yes	No
Have you experienced any penile discharge? ……………………………………………..	Yes	No
Do you regularly experience nocturnal emission? …………………………………………	Yes	No
Do you have high cholesterol? ……. ………………… ……………………………………	Yes	No
Have you experienced a high fever in the last 6 months? ………………………………..	Yes	No
Do you currently have any prostate conditions? …………………………………………..	Yes	No
Do you or have you ever had urinary infections or STD's? ……………………………	Yes	No
Have you ever taken testosterone supplements/drugs? ………………………………….	Yes	No
Have you recently had your testosterone levels checked? ………………………………	Yes	No
Have you been diagnosed with small or soft testis? ………………………………………..	Yes	No
Have you been checked for a blockage of your reproductive tract? …………………….	Yes	No
Have you had a fertility workup? …………………………………………………………….	Yes	No

If yes, what was your sperm count? Below Normal Normal Number:

What was the sperm motility? Below Normal Notes:

What was the sperm morphology? Abnormal Normal Notes:

What is your weight? How tall are you?

Other Comments:

Patient Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

While acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive;
- Minor bleeding or bruising can occur from acupuncture;
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days;
- Fainting can occur in certain patients, particularly at the first treatment;

What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?

- Bruising (looks like a circular hickey) is a common side effect of cupping;
- The herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint, or other odd detached sensations;
- If you have a pacemaker or any other electrical implants;
- If you are pregnant;
- If you have a bleeding disorder;
- If you are taking anti-coagulants (blood thinners) or any other medication;
- If you have damaged heart valves or have any other particular risk of infection.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time. I wish to rely on my practitioner to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions.
I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Privacy Policy

The information received and collected about our clients/patients from their visit to Angea Fertility is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Angea, 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 Angea (also, Angea will not give, share, sell, or transfer any personal information to a third party unless required by law). Under absolutely no circumstances would this communication happen without the signed consent of the client/patient. The client/patient information will be stored both in digital and hard copy
format on Angea premises. On occasion, Angea may use client/patient information to conduct clinical studies to help us improve upon services provided.

Full Name (Print name of representative if represented by another)

Signature (Signature of Representative)

Date

Appointment Policy

Welcome to Anjea Fertility Clinic. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy.

Many of our clients are pleased to find out that we are usually on time. This is because a treatment room has been reserved for you, whereas most medical offices overbook by appointing several patients at the same time. That kind of scheduling provides the practitioner with a steady flow of patients but does not respect the patient’s time.

Occasionally, there is a problem with patients who are not used to staying on schedule themselves. With that in mind, if you are going to be more than 15 minutes late, please call to confirm availability.

A 24 hour notice for cancelled or rescheduled appointments is necessary in order to avoid a cancellation fee of $80. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

Any questions regarding my appointments have been addressed. I have read this statement and fully understand it.

Full Name

Date

Signature