Welcome To FullMoonWater Chinese Medicine

Contact Information

First Name Last Name

Address

City State Zip

Date of Birth Home Phone

Work Phone Cell Phone

Circle Preferred Phone: Home, Work or Cell

Email Address

Do we have your permission to send appointment reminders, health newsletters, and occasional promotions to your email address? Your email will not be sold or given to any other agency. Yes _____ No _____

Emergency Contact

Name Phone

Relationship

If you have health insurance, we will be happy to verify your benefits. If you have a discount plan through your insurance, please let us know.

How did you hear about us? (Please circle)

Friend or Family (name) _____

Internet Facebook Newspaper Yellow Pages Radio Website

Insurance Company_____

Other _____

MISSION STATEMENT

FullMoonWater provides information, education, and access to complementary health services for people seeking wellness, FullMoonWater connects practitioners and neighbors to achieve optimum health. Healthy and happy people are the basis of a healthy and happy community.

DISCLAIMER

Merely an office location, through which independent practitioners conduct their business, FullMoonWater does not render any services or provide any care or treatment. The individual practitioner that performs the services is independent from FullMoonWater and is responsible for the services rendered. Additionally, not all of the practitioners at FullMoonWater are licensed medical doctors; some services available at FullMoonWater are complementary to and not a substitution for treatment by a licensed medical doctor. As such, by signing below, you indicate that you understand this disclaimer and agree to hold FullMoonWater harmless from any and all claims related to services obtained at FullMoonWater.

Signature Date

Colorado Mandatory Disclosure Statement

FullMoonWater, LLC
10268 West Centennial Rd., Suite 201
Littleton, CO 80127

TROY KREBS, L.Ac.

Troy Krebs received her degree at the Colorado School for Traditional Chinese Medicine (a credentialed 36-month program). She was trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental medicine concepts. She also studied 5-element acupuncture. She studied Chinese medicine in China to earn additional experience. Troy is certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). She is licensed to practice acupuncture in the state of Colorado and has been practicing acupuncture since 2002. She has privileges at Craig Hospital. Troy has not had any license, registration, or certification revoked or suspended.

This office complies with all rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized; and they are disposed of in a manner consistent with OSHA and Colorado State regulations.

PATIENT'S RIGHTS

Each patient who visits this office is entitled to receive information about the methods of therapy, the techniques used, and an estimated duration of therapy, if known. The patient may seek a second opinion from another health care professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies. The Colorado Department of Regulatory Agencies regulates the practice of acupuncture. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone: 303 894-7800.

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient.

Patient's Name (please print):

Signature of patient or legal guardian Date

Financial Policy For Patient Care Services

FullMoonWater wants to provide the most efficient and affordable health care services, so it is necessary for us to have a financial policy stating our requirements for timely payment of services and products provided by our office. We welcome the opportunity to discuss any aspect of our financial policy.

To help us help you, please:

1. Provide us with accurate and updated information on yourself and your insurance company.
2. Pay at the time of service for your entire balance.
3. Discuss your account balance only with the front office staff. It is important for practitioners to be allowed to provide patient care. If the front office staff cannot help you, do not hesitate to contact the office manager.

INSURANCE PATIENTS

We are happy to file for insurance as a courtesy to you. As stated by your insurance company: **"Verification of benefits is no guarantee of payment."** If you have insurance and we file with your carrier for you, you will be responsible for all charges not paid by the insurance company. The balance due is your responsibility if we have not received payment from your insurance company within 60 days.

FullMoonWater sends claims with procedure codes to the insurance companies. Your insurance company then chooses the "reasonable and customary" amount to apply to your visit. Your insurance plan is a contract between you and your insurance company, therefore any amount applied toward your deductible must be paid in full.

By signing this financial policy:

1. You are authorizing FullMoonWater, its providers, and its employees to release any necessary information related to this visit and all future visits to your insurance company for the purpose of claim(s) payment.
2. You are authorizing your insurance company and your medical provider to release your medical records to FullMoonWater for the purpose of claim(s) payment.
3. You are authorizing your insurance company to pay any medical benefits and all future claims for services provided by our office directly to FullMoonWater.
4. You are giving FullMoonWater the right to speak with your insurance company, any third party insurance company, and your attorney regarding your claims and bills.
5. You agree that a photocopy of any document is as valid and effective as the original.

FullMoonWater and its providers accept worker's compensation and auto accident insurance. We require that a lien signed by the patient and any attorneys is on file when applicable. FullMoonWater and its providers are willing to extend the expectation of payment within 60 days for worker's compensation and auto accident insurance when Med-Pay is not available.

If you prefer that we do not file insurance claims for you, you may pay the cash at time of service discounted rate and send the claim to your insurance carrier. If you choose to submit your own claims, we will provide you with a superbill, but cannot assist you in filing your claims.

SELF-PAY PATIENTS

If you do not have insurance or our services are not covered by your insurance company, you will be considered a "self-pay" patient. Family plans and discounts must be applied at the time of service and cannot be back-dated. If you have a financial hardship, an application for financing or a financial hardship discount must be completed before or at the time of service. It is important to FullMoonWater that you become well now, even if we need to work with your financial budget.

CANCELLATION POLICY

In order to provide you with the best care, please arrive 10 minutes prior to your appointment – late arrival may result in cancellation. We require 24 hours' notice of cancellation or you may be charged a fee. Please remember that failure to appear for your appointment prevents others from receiving care.

FINANCE CHARGES

Failure to pay for services and products provided by our office will result in a finance charge. If we need to forward your account over to a collections agency for further legal action, you will be responsible for the entire balance on your account plus any collection fees.

PAYMENT OPTIONS

Cash or checks only. No credit cards.

CASH AT TIME OF SERVICE SAVINGS

Service

- Acupuncture Initial Consultation & Treatment
- Single follow-up visit
- 5 follow-up visits – save $10 per treatment
- 10 follow-up visits – save $15 per treatment
- 20 follow-up visits – save $20 per treatment
- Tibetan Cranial Sacral Work
- Fertility Treatments Transfer (IUI/IVF)

Notes: Coupons or other special discounts may apply.

Herbs are purchased separately.

Insurance is billed by code; payment varies by plan.

Patient's Name (please print)

Responsible Party or Authorized Person Signature Date

FullMoonWater Signature Date

FullMoonWater
Chinese Medicine

Acupuncture Informed Consent

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

Acupuncture, acupressure, Moxa, cupping therapy, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury. We recommend that you CONSULT YOUR PHYSICIAN for any serious conditions and receive at least two medical opinions. It is your right and responsibility for your own body.

I understand that complications may result from acupuncture treatment. Among these possible complications are: areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, Pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia or Coumadin use. Please use caution when walking with bare feet in the treatment room.

I further understand and agree to hold harmless, to indemnify and to protect against court action the individual therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

PAYMENT PRACTICES

FullMoonWater gladly accepts health insurance, automobile insurance, and worker's compensation as payment. Insurance coverage depends upon your individual plan. Please call your insurance company to verify your acupuncture benefits. In the event your insurance does not cover acupuncture, discounted charges will be collected at the time of service.

PAYMENT AGREEMENT

I authorize FullMoonWater to release any information required to process this claim to any insurance company or attorney in this case. I also authorize my insurance company or medical provider to release my medical records to FullMoonWater. This information is to be used for the purpose of processing my claims for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original.

I hereby authorize my insurance benefits to be paid directly to FullMoonWater. I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by FullMoonWater.

I agree to pay charges and services not covered by any insurance or other third-party payer and/or not paid to FullMoonWater for any reason within a reasonable time (as determined by FullMoonWater). The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator, or third party responsible for payment of the charges.

CANCELLATION NOTICE

Please be considerate of your appointment time. We make every effort to respect your time and see you promptly when you are scheduled. Please call if you cannot make your appointment or you are running late. Patients who consistently miss their appointments or fail to cancel 24 hours in advance may be charged for their missed appointments.

I have read and understand the above Informed Consent statement. I agree to the conditions set forth in this statement.

Patient's Name (please print)

Responsible Party or Authorized Person Signature Date

Privacy Practices

As your health care provider, we use your health information for evaluation and treatment; as well as to obtain payment for treatment. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers. We may use your health care information without your authorization for the following reasons: public health safety, auditing purposes, emergencies, at the request of your insurance carrier, or when required by law.

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time. If you would like to review our "Notice of Privacy Practices," please request a copy at the front desk. If, at any time, we change our policies regarding your medical information, you will be informed with a new "Privacy Practices" form to sign, as well as a new copy of "Notice of Privacy Practices."

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information is corrected or added to your medical record.

If you have any questions or concerns about your medical records, please contact FullMoonWater, or you can file a written complaint with the U.S. Department of Health and Human Services. FullMoonWater is required by law to protect your medical information and provide this notice to you, along with your signature acknowledging your receipt of this information.

FullMoonWater reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices." You may obtain a revised "Notice of Privacy Practices" by notifying the office of FullMoonWater and requesting a revised copy. Our office sends thank you cards for referrals, periodic newsletters, and participates in other non-private contact. This may be via email or postal service. Reminders of your appointments may be via email or telephone.

CONSENT

I understand that I have a right to read the "Notice of Privacy Practices" prior to signing this form. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations at FullMoonWater. This "Notice of Privacy Practices" also describes my rights, as well as the duties of the practitioner with respect to my protected health information.

I consent to the use or disclosure of my protected health information by FullMoonWater for the purpose of analyzing, diagnosing, or providing treatment; as well as obtaining payment for my health care bills or to conduct health care operations. I understand that analysis and treatment by Acupuncture Associates may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. FullMoonWater is not required to agree to the restrictions that I may request. If FullMoonWater agrees to a restriction that I request, the restriction is binding on FullMoonWater. I have the right to revoke this Consent, in writing, at any time, except to the extent that FullMoonWater has taken action in reliance on this Consent.

My "protected health information" means health information, including any demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition that identifies me, or there is a reasonable basis to believe the information may identify me.

Responsible Party or Authorized Person Signature Date

FullMoonWater
Chinese Medicine

Acupuncture
Patient Information

Please complete this form as thoroughly as possible. Some questions may seem unrelated to your condition, but the answers may affect your diagnosis and treatment. All information is confidential.

First Name _____ Last Name _____ Date _____

Gender (Please circle) M F Date of Birth _____ Age _____

Marital Status (Please circle) Single Married Separated Divorced

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Place of Employment _____ Occupation _____

Insurance Coverage (Please circle) Health Ins. Auto Injury Worker's Comp None

How did you hear about us? (Please circle)

Friend or Family (name) _____

Internet Facebook Newspaper Yellow Pages Radio Website

Insurance Company _____ Other _____

Major complaints, in order of importance to you:

#1 _____ Severe _____ Moderate _____ Slight _____

Describe your symptoms _____

When/how did this condition occur? _____

How does this condition impair your daily activities? _____

Treatments you have received for this condition? _____

Do you feel better since the onset of this condition? _____

#2 _____ Severe _____ Moderate _____ Slight _____

Describe your symptoms _____

When/how did this condition occur? _____

How does this condition impair your daily activities? _____

Treatments you have received for this condition? _____

Do you feel better since the onset of this condition? _____

#3 _____ Severe _____ Moderate _____ Slight _____

Describe your symptoms _____

When/how did this condition occur? _____

How does this condition impair your daily activities? _____

Treatments you have received for this condition? _____

Do you feel better since the onset of this condition? _____

Please rate your commitment to feeling better (On a scale of 1-10): _____

What are your goals for your acupuncture visits? _____

Have you had acupuncture treatments before? _____

Do you have any concerns about having acupuncture? _____

FullMoonWater
Chinese Medicine

Acupuncture
Medical Conditions

Please list conditions and surgeries you have had, along with the year diagnosed:

Year Condition/Surgery

_____ _____

_____ _____

_____ _____

Please list all prescription medications you take, including those you use occasionally, and Inhalers, nose sprays, and eye drops:

Medication/Dose	Purpose	Length of Time	Last Dose

Please list all supplements you take including vitamins:

Medication/Dose	Purpose	Length of Time	Last Dose

Please list any allergies (seasonal, medications, environmental, food, etc.):

_____

Please list any occupational concerns (stress, computer work, heavy lifting, etc.):

_____

Please tell us about your exercise (regular, minimal, etc.):

_____

Musculoskeletal (Please check areas where you have problems, if any):

☐ Muscle Cramps ☐ Muscle Pain ☐ Joint Swelling

☐ Tendonitis ☐ Arthritis ☐ Bursitis

Please label (A,B,C,D) problem areas on the diagram, then answer the questions about each area:

A: Sharp _____ Burning _____ Aching _____

Fixed_____ Other _____

B: Sharp _____ Burning _____ Aching _____

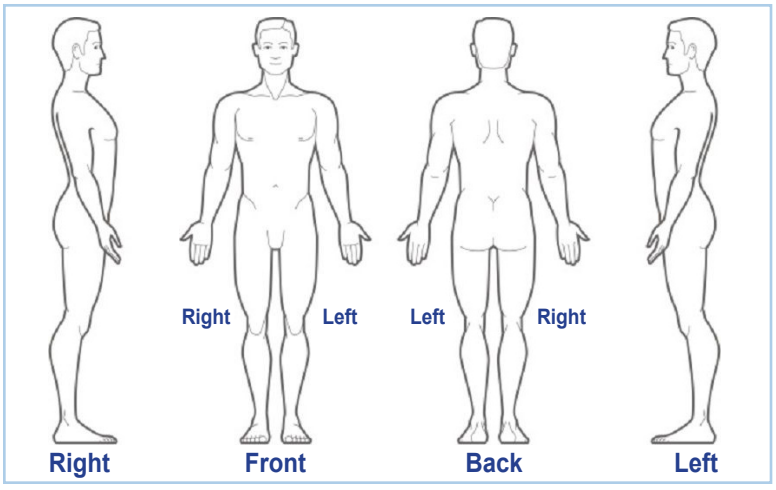
Fixed_____ Other _____

C: Sharp _____ Burning _____ Aching _____

Fixed_____ Other _____

D: Sharp _____ Burning _____ Aching _____

Fixed_____ Other _____



FullMoonWater
Chinese Medicine

Acupuncture
Medical Conditions (Cont)

SYMPTOMS

Note: For each symptom you currently have, rate its severity on a scale from 1- 5. (1 being the least severe and 5 being the most severe). Leave blank if not applicable.

LIVER / GALLBLADDER

_____ Irritability / Anger
_____ Depression / Stress
_____ Headaches / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness
_____ Blurred Vision
_____ Feeling of Lump in Throat
_____ Clenching of Teeth at Night
_____ Muscle Cramping / Twitching
_____ Tension
_____ Joints/Neck/Shoulder Pain/Tight
_____ Poor Circulation
_____ Soft / Brittle Nails
_____ Emotional Eater

KIDNEY / URINARY BLADDER

_____ Urinary Problems
_____ Bladder Infection
_____ Lack of Bladder Control
_____ Weakness / Pain in Lower Back
_____ Decreased Bone Density
_____ Feel Cold Easily
_____ Low Sex Drive
_____ Excess Sexual Desire
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities
_____ Craving / Avoiding Salty Foods
_____ Fear
_____ Hot Flash /Night Sweating

HEART / SMALL INTESTINES

_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life

LUNG / LARGE INTESTINE

_____ Dry Cough
_____ Cough with Sputum
_____ Nasal Discharge
_____ Post-Nasal Drip
_____ Sinus Infection / Congestion
_____ Itchy, Red or Painful Throat
_____ Dry Mouth / Throat / Nose
_____ Skin Rashes / Hives
_____ Snoring
_____ Grief / Sadness
_____ Shortness of Breath
_____ Allergies / Asthma
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever Comes & Goes
_____ Smoke Cigarettes

SPLEEN / STOMACH

_____ Heaviness Anywhere in Body
_____ Fatigue / Worse After Eating
_____ Hard to Get Up in the Morning
_____ Edema (Swelling)
_____ Muscles Feel Tired Often
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____ Decreased / Increased Appetite
_____ Crave Sweets
_____ Hypoglycemia
_____ Difficulty Digesting Oily Foods
_____ Nausea / Vomiting
_____ Gas / Belching
_____ Insulin Sensitivity
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over-Thinking
_____ Tendency to Gain Weight
_____ Brain Foggy

BODY TEMPERATURE (Please check any that apply)

_____ Cold Entire Body
_____ Cold Extremities
_____ Hot All Day
_____ Hot Only in Afternoon
_____ Hot Only at Night
_____ Normal

ENERGY LEVEL (Please circle) LOW 1 2 3 4 5 6 7 8 9 10 HIGH

FullMoonWater
Chinese Medicine

Personal Medical & Family Health History

Please indicate those that are **current** health problems for yourself and your family members with a **"C"** under the appropriate person's column. **"P"** should be used to indicate a **past** problem. Leave blank those that do not apply.

Conditions	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
AIDS/HIV											
Alcohol											
Anxiety											
Arthritis											
Asthma /Hay Fever/Allergy											
Back trouble											
Bursitis											
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Tobacco											
Weight Problem											
Other Emotional Problems:											
Other:											

If any of the above family members are deceased, please list their age at time of death and cause:

_____

_____

_____

FullMoonWater
Chinese Medicine

Acupuncture
Personal Information

For Women Only

Have you had a hysterectomy? ☐ Yes ☐ No

Ovaries removed? ☐ Yes ☐ No

Post-menopausal bleeding? ☐ Yes ☐ No

Could you be pregnant at this time? ☐ Yes ☐ No

Number of: Pregnancies _____ Births _____

Miscarriages _____ Abortions _____

When did your last period end? _____

Number of days in your monthly cycle? _____

Number of days bleeding lasts? _____

Describe menstrual flow:
☐ Heavy ☐ Moderate ☐ Light ☐ None

Color of menstrual flow:
☐ Dark ☐ Bright Red ☐ Slightly Reddish

Birth Control:
☐ None ☐ Birth Control Pills ☐ IUD
☐ Spermicides ☐ Barriers ☐ Other _____

Do you suffer from cramping? ☐ Yes ☐ No
☐ Before period ☐ During period ☐ After period
☐ Mild ☐ Moderate ☐ Severe

Clotting? ☐ Yes ☐ No
☐ Bright in color ☐ Dark in color

Do you suffer from any of the following:
☐ Bleeding between periods ☐ Infertility
☐ Pelvic Inflammatory Disease ☐ Ovarian cysts
☐ Endometriosis ☐ Hot Flashes ☐ Mastitis
☐ Breast Cysts ☐ Yeast Infections/Vaginitis

☐ Other _____

Premenstrual Syndrome
☐ Fluid Retention ☐ Fluctuating Emotions
☐ Cravings ☐ Irritability ☐ Depression
☐ Tenderness in Breasts ☐ Fatigue

For Men Only

☐ Impotence ☐ Testicular Pain/Lump
☐ Weak Erection ☐ Discharge from Penis
☐ Infertility ☐ Prostate Problems
☐ Premature Ejaculation ☐ Low Sex Drive

For Women and Men
Diet Information

Please describe your appetite:
☐ Strong ☐ Normal ☐ Poor

Do you hunger quickly? ☐ Yes ☐ No

Please describe your diet (low-fat, low-carb, vegetarian, etc.): _____

_____

Please list what you ate yesterday:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

How much water do you drink per day? _____

Other fluids? _____

Please describe your thirst:
☐ Strong ☐ Normal ☐ Poor

If you eat any of the following, please check and list how much per week:

☐ Candy _____
☐ Cookies/Baked goods _____
☐ Chocolate _____
☐ White flour bread _____
☐ Soda - Regular/Diet _____
☐ Milk _____
☐ Cheese _____
☐ Yogurt _____
☐ Eggs _____
☐ Ice-cream _____
☐ Pasta _____
☐ Coffee _____
☐ Alcohol _____
☐ Fast Food _____
☐ Protein _____
☐ Dark Green Vegetables _____
☐ Fruit _____
☐ Other _____

FullMoonWater
Chinese Medicine

Acid-Alkaline Questionnaire

SECTION A – HISTORY

Circle the number score for each yes answer.

1.	Have you taken tetracyclines (Sumycin, Panmycin Minocin, Vibramycin, etc.) or other antibiotics for one month or longer?	35
2.	Have you ever taken other "broad spectrum" antibiotics for urinary, respiratory, or other infections for two months or longer, or in shorter courses, four or more times in a one-year period?	35
3.	Have you ever taken a "broad spectrum" antibiotic?	6
4.	Have you ever been bothered by persistent prostatitis, vaginitis, or other reproductive organ problems?	25
5.	Have you been pregnant two or more times?	5
	Pregnant one time?	3
6.	Have you taken birth control pills for more than two years?	15
	For six months to two years?	8
7.	Have you taken Prednisone, Decadron, or other cortisone-type drugs for more than two weeks?	15
	For two weeks or less?	6
8.	Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke moderate to severe symptoms?	20
	Mild symptoms?	5
9.	Are symptoms worse on damp, muggy days, or in moldy places?	20
10.	Have you had severe or persistent athlete's foot, ring worm, jock itch, or chronic fungus infections of the skin or nails?	20
	Mild to moderate?	10
11.	Do you crave sugar?	10
12.	Do you crave breads?	10
13.	Do you crave alcoholic beverages?	10
14.	Does tobacco smoke really bother you?	10

SECTION A TOTAL _____

SECTION B – MAJOR SYMPTOMS

Enter the appropriate score for each symptom below.
If a symptom is occasional or mild, score 3 points.
If a symptom is frequent or moderately severe, score 6 points.
If a symptom is severe or disabling, score 9 points.

1. Fatigue or lethargy _____
2. Feeling of being "drained" _____
3. Poor memory _____
4. Feeling "spacey" or "unreal" _____
5. Depression _____
6. Numbness, burning, or tingling _____
7. Muscle aches _____
8. Muscle weakness or paralysis _____
9. Joint pain _____
10. Abdominal pain _____
11. Constipation _____
12. Diarrhea _____
13. Bloating _____
14. Troublesome vaginal discharge _____
15. Persistent vaginal burning or itching _____
16. Prostatitis _____
17. Impotence _____
18. Loss of sexual drive _____
19. Endometriosis _____
20. Cramps or other menstrual irregularities _____
21. Premenstrual tension _____
22. Spots in front of eyes _____
23. Erratic vision _____

SECTION B TOTAL _____

SECTION C – OTHER SYSTEMS

Enter the appropriate score for each symptom:
If a symptom is occasional or mild, score 1 point.
If a symptom is frequent or moderately severe, score 2 points.
If a symptom is severe or disabling, score 3 points.

1. Drowsiness _____
2. Irritability or jitteriness _____
3. No coordination _____
4. Inability to concentrate _____
5. Frequent mood swings _____
6. Headaches _____
7. Dizziness/loss of balance _____
8. Pressure above ears, head tingling _____
9. Itching _____
10. Rashes _____
11. Heartburn _____
12. Indigestion _____
13. Belching and intestinal gas _____
14. Mucus in stools _____
15. Hemorrhoids _____
16. Dry mouth _____
17. Rash or blisters in mouth _____
18. Bad breath _____
19. Joint swelling or arthritis _____
20. Nasal congestion or discharge _____
21. Postnasal drip _____
22. Nasal itching _____
23. Sore or dry throat _____
24. Cough _____
25. Pain or tightness in chest _____
26. Wheezing or shortness of breath _____
27. Urgency or urinary frequency _____
28. Burning on urination _____
29. Failing vision _____
30. Burning or tearing of eyes _____
31. Recurrent infections or fluid in ears _____
32. Ear pain or deafness _____

SECTION C TOTAL _____

GRAND TOTAL SCORE _____

Your Grand Total Score will help determine if your health problems are yeast-connected.

Yeast-connected health problems are:	Women	Men
Almost certainly present with scores over	180	140
Probably present with scores over	120	90
Possibly present with scores over	60	40

Women with scores less than 60 and men with scores less than 40 are less apt to have yeast-connected health problems.

FullMoonWater
Chinese Medicine

Women's Fertility History

Confidential

Name of your doctor / fertility specialist: Conceptions / CCRM / Dr. Trout / Dr. Smith / Kaiser / University Hospital / Other OBGYN Doctor: _____ Name of person who told you about us: _____

Start date: month/year _____ Current Month Treatment Plan _____ (IVF / IUI / Natural / Tests / Etc.)

1. Please list below all pregnancies and fertility treatments (including cancelled cycles)

Date	Natural, IUI, IVF, Other	Medication Used	# of Mature Eggs / Follicles	Pregnancy Yes / No	If Miscarried, which week	Other Comments and Locations

2. Do you have any of these diagnoses?

	High FSH	Uterine Fibroids / Polyps	Endometriosis / Adhesions	PCOS	POF	Low Progesterone Level
Date						

3. Have you ever had any of these infertility tests or procedures?

	Laparoscope	HSG - Hysterosalpingography	Others
Date			

4. Do you have any of these? If yes, please list how many:

Pregnancies	Children	Miscarriages	Abortions	Ectopic	D&C	Abnormal Pap Smear	Other

5. Other:

Age at which menses began? _____
Do you take birth control? _____ If yes, how long? _____
List name of birth control _____
Has your husband been checked out for fertility problems? _____
How long have you been trying to get pregnant? _____
At Day 3 _____ at Day 10 _____ at _____ (month/year)
Do you get recurrent yeast infections? How often? _____

Do you have to do a Clomid challenge test? _____
Do you ovulate on your own? _____
How can you tell you ovulate? _____
Which day of your cycle? _____ to _____
Have you done BBT testing? _____
Typically, how many days are there from one period to the next _____ to _____ days?
Today is which day of your cycle? _____

6. List any PMS symptoms before period:

	10 Days Before	1 Week Before	2-3 Days Before
Breast Tenderness			
Depression			
Fatigue			
Low Back Pain			
Face Breakout			
Other			

7. How is your period each day? Please check each day:

Symptoms (please check each day)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6-7
Do you have back pain?						
Cramp? (Light, Medium, Severe)						
Flow Color? (Light Red / Red / Dark Red / Brown)						
How Heavy is Flow? (Light, Normal, Heavy)						
Is there Clotting?						
Is there Spotting?						