CEDAR FOREST WELLNESS

ACUPUNCTURE
HERBAL APOTHECARY
MADISON WISCONSIN

Name:

Date of Birth:

Mailing Address:

Preferred Telephone Numbers (cell, work, or home):

E-mail address:

Emergency Contact:

Relationship:

Phone:

Current Physician:

Phone/contact for physician:

Have you had acupuncture before? ☐ YES ☐ NO

What are you questions/concerns, if any about treatment?

I have a minimum 48 hours cancellation policy. Please be aware that it is difficult to fill your appointment even with 48 hours notice. I appreciate as much notice as possible. I reserve your appointment time especially for you.

I do not double or triple book appointment times. This allows me to spend more time with each individual patient and manage my time effectively so as not to inconvenience you. Policies aside, I know that life often intervenes at the last moment and some situations cannot be avoided. I will work with you and appreciate your attentiveness to this matter.

I ask for payment to be made at the time of your visit. Our bank charges us a $15.00 fee for any bounced checks. Therefore, if you bounce a check, please be prepared to pay that fee.

Signature: _____ Date: _____
(or patient representative)

Print: _____ _____
(Indicate relationship if signing)

Matthew Brookman L.Ac • Cedar Forest Wellness
Madison • Wisconsin • 608-866-0064

CEDAR FOREST
WELLNESS

Matthew Brookman M.Ac, L.Ac, Dipl.Om

Men's Fertility History

CONFIDENTIAL

Name (Last, First , Middle)	Date

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

How would you describe your libido? ☐ Low ☐ Normal ☐ High

	Yes	No
Have you ever been diagnosed with a varicocele?	☐	☐
Have you had any urologic surgeries?	☐	☐
Have you experienced difficulty maintaining an erection?	☐	☐
Have you experienced difficulty ejaculating?	☐	☐
Have you had exposure to any known environmental toxins of hormones?	☐	☐
Have you experienced any abnormal penile discharge?	☐	☐
Do you regularly experience nocturnal discharge?	☐	☐
Have you have a fertility work up?	☐	☐

If yes, what was your sperm count?

☐ Normal ☐ Below Normal Number: _____

What was the sperm motility?

☐ Normal ☐ Below Normal Notes: _____

What was the sperm morphology?

☐ Normal ☐ Below Normal Notes: _____

Comments/Notes/Additional Concerns:

_____

_____

_____

_____

_____

_____

HEALTH HISTORY

CONFIDENTIAL

Name (Last, First, Middle)	Date

Chief Compliant (Keep it simple - only list current complaints) What you are seeking care for?

1.

2.

3.

How long has this condition persisted?		
Is there anything that makes it better?		
Is there anything that makes it worse?		
Have you ever received treatment for this condition? ☐YES ☐NO	If yes when?	
Where?	By whom?	
What was the diagnosis?	What kinds of treatment?	
What were the results of treatment?		

List any substances you are allergic to:

List any medication/supplements you are currently taking (if more attach a separate list):	DOSE:	FOR WHAT CONDITION:	FOR HOW LONG:

List any major surgeries you have had:

DATE	PROBLEM/SURGERY

Significant trauma (auto accidents, falls, etc.)

DATE	

SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

☐ Asthma ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Gallstones ☐ Heart Disease ☐ Hepatitis ☐ HIV Positive ☐ Hypertension ☐ Seizures ☐ Thyroid Disease ☐ Other: _____

HEALTH HISTORY **CONFIDENTIAL**

NAME (LAST, FIRST, MIDDLE):	DATE:

Please check any symptoms you currently have or have had in the past year

General

- ☐ Chills
- ☐ Low energy
- ☐ Dizziness
- ☐ Allergies
- ☐ Fatigue
- ☐ Fevers
- ☐ Insomnia
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweat spontaneously
- ☐ Night sweating
- ☐ Lack of sweating
- ☐ Weight gain
- ☐ Weight loss
- ☐ Easy bruising
- ☐ Aversion to heat
- ☐ Aversion to cold

Vision

- ☐ Blurred vision
- ☐ Heaviness in the head
- ☐ Headache
- ☐ Cataract
- ☐ Double vision
- ☐ Red/inflamed eye
- ☐ Eye pain/strain
- ☐ Corrected vision
- ☐ See Floaters

Mouth/Thirst

- ☐ Sores on lips/tongue
- ☐ Taste change
- ☐ Mouth feels dry
- ☐ Crave Large amounts of liquid
- ☐ Crave small amounts of liquid
- ☐ Strange taste in mouth
- ☐ Teeth problems
- ☐ Friends/partner/you say you have bad breath

Ears

- ☐ Earache
- ☐ Ear discharge
- ☐ Ringing in ears
- ☐ Hearing loss

Sinus/Nasal

- ☐ Nasal obstruction
- ☐ Nasal discharge
- ☐ Loss of sense of smell
- ☐ Sinus problems
- ☐ Nosebleeds
- ☐ Recurrent sore throat
- ☐ Phlegm in throat

Cardiovascular

- ☐ Awareness of heartbeat/ palpitations
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

Respiratory

- ☐ Asthma
- ☐ Hay fever
- ☐ Persistent cough
- ☐ Coughing blood
- ☐ Shortness of breath
- ☐ Recurrent bronchitis
- ☐ Phlegm Production
- ☐ Difficulty inhaling
- ☐ Difficulty exhaling

Urination

- ☐ Dilute urine
- ☐ Dark urine
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Burning urination
- ☐ Scanty urine
- ☐ Profuse urine
- ☐ Frequent urine
- ☐ Frequent nighttime urine
- ☐ Poor bladder control
- ☐ Urgency to urinate

Weight

- ☐ Underweight
- ☐ Normal for height
- ☐ Overweight
- ☐ Very overweight

Bowels (check all that apply)

- ☐ Formed
- ☐ Unformed
- ☐ Sticky
- ☐ Foul odor Incomplete evacuation
- ☐ Wipe more than 3-4 times?
- ☐ Have to deep-breathe/ push to initiate a bowel movement
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea/loose stools
- ☐ Bloody stools
- ☐ Hemorrhoids

Gastrointestinal

- ☐ Difficulty swallowing
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Belching
- ☐ Poor appetite
- ☐ Nausea
- ☐ Heartburn/reflux
- ☐ Indigestion
- ☐ Vomiting
- ☐ Vomiting blood

HEALTH HISTORY **CONFIDENTIAL**

NAME (LAST, FIRST, MIDDLE):	DATE:

Please check any symptoms you currently have or have had in the past year

Neurological

- ☐ Fainting
- ☐ Convulsions/Seizures
- ☐ Change in handwriting
- ☐ Paralysis
- ☐ Stroke
- ☐ Tremor
- ☐ Recent clumsiness
- ☐ Drowsiness
- ☐ Vertigo

Emotional

- ☐ Insomnia
- ☐ Irritability
- ☐ Often feel angry
- ☐ Frequent Sighing
- ☐ You have "11" lines between eyebrows (knitted brow)
- ☐ Troubling dreams
- ☐ Cry uncontrollably
- ☐ Feel sad a lot
- ☐ Forgetful
- ☐ Mind not clear
- ☐ Anxiety
- ☐ Much fear
- ☐ Mania/
- ☐ Terrors
- ☐ Difficultly expressing emotions
- ☐ You have unfulfilled desires and goals in your life.
- ☐ Your friends or partner would describe you as grumpy, irritable, impatient, frustrated
- ☐ Friends or partner would say you hold grudges.

Diet/Lifestyle

- ☐ Vegetarian
- ☐ Healthy diet
- ☐ Eat much fried foods
- ☐ Eat much meat
- ☐ Eat a lot of sweats
- ☐ Large appetite/always finish every meal/rapid hungering
- ☐ Drink Coffee
- ☐ Drink Alcohol
- ☐ Cannabis Use
- ☐ Exercise regularly
- ☐ Exercise excessively

Skin

- ☐ Thick skin
- ☐ Thin Skin
- ☐ Dry skin
- ☐ Acne
- ☐ Broken blood vessels
- ☐ Blood not clotting
- ☐ Bruise easily
- ☐ Discoloration
- ☐ Dark circles around eyes
- ☐ Bags under eyes
- ☐ Lumps in groin
- ☐ Lumps in underarm
- ☐ Brittle nails

Hair

- ☐ Premature gray hair
- ☐ Dry/brittle hair
- ☐ Hair falling out

Musculoskeletal:

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Feet
- ☐ Hands
- ☐ Joints
- ☐ Legs
- ☐ Knee(s)
- ☐ Hips
- ☐ Neck
- ☐ Shoulders
- ☐ Pain everywhere
- ☐ Cold limbs
- ☐ Low back
- ☐ Lack of strength
- ☐ Broken bones
- ☐ All over weakness
- ☐ Frequent muscle twitching
- ☐ Cramping of muscles - especially nighttime
- ☐ Joints frequently popping/cracking noise

Women Only

- ☐ May be pregnant
- ☐ Abnormal pap smear
- ☐ Contraceptives
- ☐ Low libido
- ☐ Vaginal discharges
- ☐ Uterine prolapse
- ☐ Endometriosis
- ☐ Facial hair
- ☐ Loss of head hair
- ☐ Menopausal

Menstruation

- ☐ Bleed between periods
- ☐ Irregular periods
- ☐ Heavy Periods (excessive volume of menstrual blood)
- ☐ Painful Periods
- ☐ PMS (Sore breasts, irritability, cramping, etc.)
- ☐ < 25 day cycle
- ☐ > 35 day cycle
- ☐ Menses > 5 days
- ☐ Menses < 3 days
- ☐ No Menses

Menopause/ Perimenopause

- ☐ Hot Flashes
- ☐ Dryness
- ☐ Irritability
- ☐ Insomnia
- ☐ Bone density

Men Only

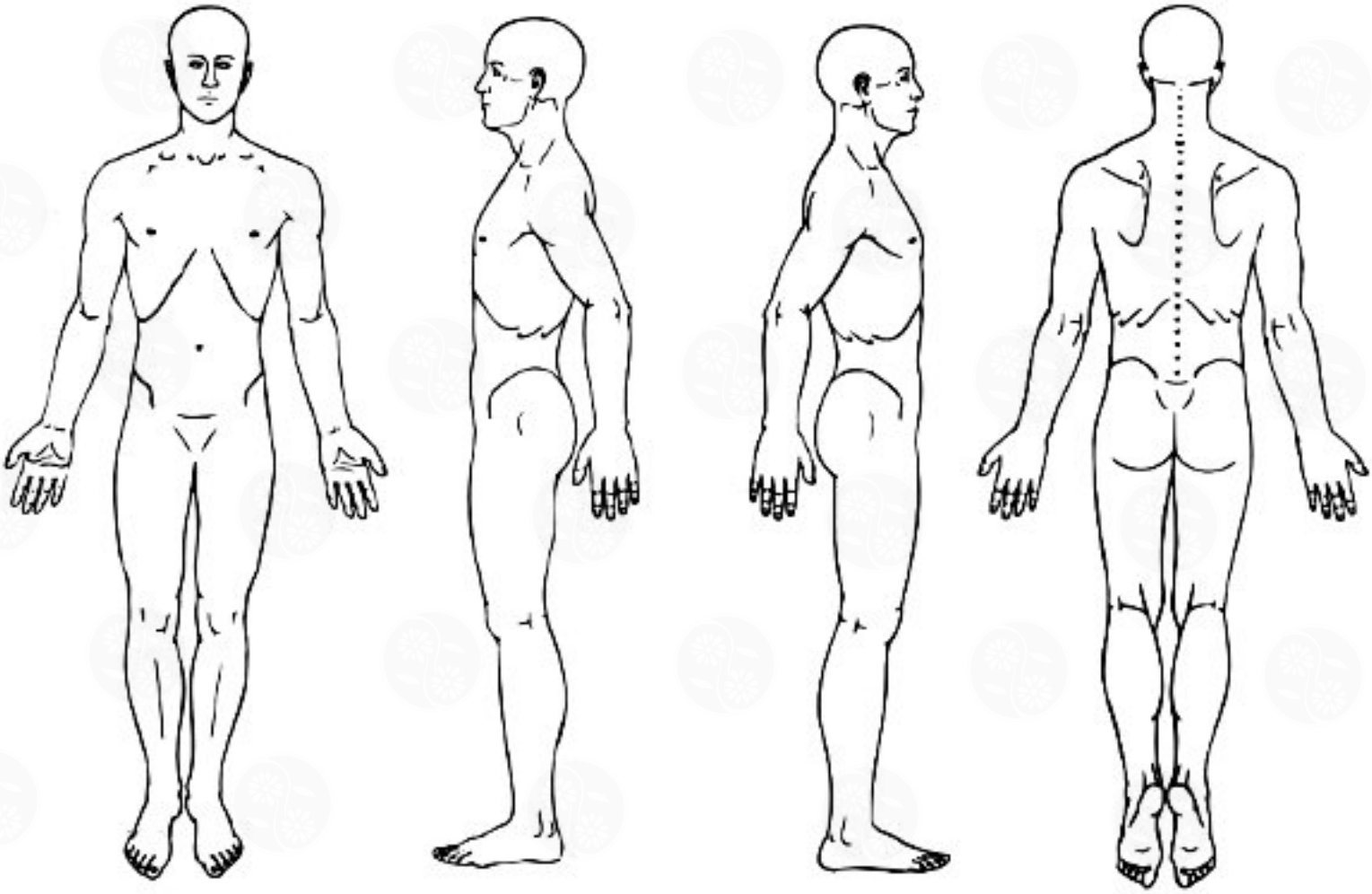
- ☐ Genital pain
- ☐ Impotence
- ☐ Genital sores
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Nocturnal emission
- ☐ Low libido

PAIN ASSESSMENT

NAME (LAST, FIRST, MIDDLE):	DATE:

1. ☐ Initial Visit ☐ Follow-up Visit

2. Please mark or shade the areas of your body where you feel pain on the diagrams below



3. Next to each area marked above, please note the intensity of pain

No Pain	Minimal		Tolerable but hinders activities		High -50% of activities impaired		Extreme -most activities impaired		Unbearable	
0	1	2	3	4	5	6	7	8	9	10

CONSENT TO SERVICES

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture and Chinese medicine on me (or on the patient named below, for whom I am legally responsible) by Matthew Brookman and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as back-up for

Matthew Brookman, including those working at the clinic or office listed or any other office clinic, whether signatories to this form or not. I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, gua sha, cupping, electrical stimulation, tui-na (Chinese massage), Chinese herbs and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a dew days, and rarely dizziness or fainting. Very rare and unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable single-use needles and maintains a clean and safe environment.

Burns and/or scarring are a potential risk of heat treatments using Artemesia vulgaris (moxibustion, "moxa") or a conventional heat lamp. The heat generated from the moxa treatments may involve slight discomfort or leave a blister or scar on the skin. With any type of heat, there is always a risk of a burn.

Bruise-like marks are common side effect of cupping and gua sha. Cupping and a massage technique called "gua sha" leaves redness, or red/purple marks on the skin that can last for 1- 5 days, in rare cases cupping marks take more then 3 weeks to fade. Slight bruising and tenderness may persist after the treatment.

The herbs and/or nutritional supplements that have been recommended are traditionally considered safe, although some may be toxic is large doses. I understand that the herbs and supplements may need to be prepared and the teas consumed according to the instructions unanticipated or unpleasant effects associated with the consumption of the herbs or nutritional supplements.

I understand that this document describes the major risks of treatment, other side effect and risks may occur. 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 possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that the results are not guaranteed.

I understand the clinical and administrative staff may review my patient 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, or have had read to me, the above consent to treatment, I have been told the risks and benefits of acupuncture and other procedures, 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 for any future condition(s) for which I seek treatment.

Name: _____ Date: _____

Signature: _____
(or patient representative)

_____
(Indicate relationship if signing for patient)