Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, AOMA is required to have you respond affirmatively to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no.

(Pursuant to the requirements of section 183.10(a)(11) of this title and section 205.302 V.A.C.S. article 4495b, governing the practice of acupuncture)

I (patient's name) _____
am notifying the AOMA Graduate School of Integrative Medicine of the following:

___ Yes___No I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

___ Yes___No I have received a referral from my chiropractor within the last 30 days for acupuncture. The date of the referral is_____, and the most recent date of treatment prior to acupuncture treatment is_____.
After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

___ Chronic Pain
___ Smoking addiction
___ Weight loss
___ Alcoholism
___ Substance abuse
Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

_____ _____
Patient Signature Required Date

The acupuncturist has referred me to a physician. It is my responsibility and choice to follow his/her advice.

_____ _____
Patient Signature Required Date

_____ _____
Acupuncturist's Signature Date

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the "Notice of Privacy Practices". I understand that I have the right to review AOMA's "Notice of Privacy Practices" prior to signing this document. I understand that AOMA staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.
I also understand that my clinical information may be used for educational and/or research purposes by AOMA or individuals authorized by AOMA. All information that can identify me personally will be removed.
By signing this form, I am giving AOMA authorization to contact me and am giving my informed consent to utilize my information for research and educational purposes. I acknowledge that all information discussed during the assessment and treatment at AOMA Clinics will be held confidential except in the instance where my safety or the safety of others may be at risk

_____ _____
Patient Name (print) Date

_____ _____
Patient Signature AOMA Privacy Rep/Date

Authorization for Release of Health Information (Optional)

I,_____, hereby authorize the AOMA Graduate School of Integrative Medicine the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____ _____

_____ _____

_____ _____

_____ _____
Patient's Signature Date

INFORMED CONSENT TO CHINESE MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the student interns and/or the licensed acupuncturists on staff at the AOMA Graduate School of Integrative Medicine (AOMA) who now or in the future treat me while employed by, working or associated with or substituting for AOMA, including those working at this clinic or any other associated clinics: acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with my student interns, professional practitioners, and/or with other clinic personnel the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from those locations; nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I understand that acupuncture and Oriental medicine treatments may not have the desired therapeutic affect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is reasonable cause to believe that treatment is not appropriate for a patient who is under the influence of illegal drugs, alcohol, or appears to be overly medicated, then a treatment may not be performed at that time. The patient will be informed that they may not be treated at that time and will be requested to reschedule their appointment

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures and conditions of treatment. 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 at the AOMA clinic.

Patient's name (please print)	Patient's signature
Print Name of Patient's Representative (if applicable)	Relationship or Authority of Patient's Rep.
Signature of Patient's Representative (if applicable)	Date Signed

Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Preferred title Δ Mr. Δ Mrs. Δ Ms./Miss Δ Dr. Δ He/His Δ She/Her Δ Ze/Hir Today's date
First name Last name Middle initial
Birth Date: Time: Location:
Gender Identification: Age Occupation
Main phone # Other phone #
E-mail address Allow email contact by Dr. Morris? Δ Yes Δ No
Address: Street City State Zip
Relationship status # of children Physician: Practitioners:
Do you have health insurance? Δ Yes Δ No If yes, name of insurance company
Does your insurance cover acupuncture? Δ Yes Δ No Δ ? Who is your employer?
Emergency contact name Phone
How did you find out about our clinic? Δ *Friends/Relatives(name)*_____ ⌋ *Direct mail* Δ *Location / Walk by* Δ *Website* Δ *Referred by*_____ ⌋ *Health Fair/ Public Event* Δ *Periodicals* Δ *Other (please specify)*

Main problem(s): _____

_____.

What diagnosis, if any, have you received for this problem? _____

When did this problem begin?_____ What are the causes of this problem? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

What kind of treatment have you tried? _____

What makes this problem worse? _____

What makes this problem better? _____

Is there anybody in your family with the same/similar problems? _____

Remarks and additional information: _____

Medical History (Please include the month/year when the event occurred or when the diagnosis was established)

Surgeries:_____ **Hospitalization:** _____

Significant trauma: (auto accidents, sports injuries, etc) _____

Allergies: (drugs, chemicals, foods, environmental):_____

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

_____

Occupation: _____ Do you usually work Δ indoors Δ outdoors?

Occupational stress (chemical, physical, psychological, etc): _____

Personal Height_____ Weight now_____ Weight one year ago_____

Weight maximum_____@Year _____

Habits Do you smoke ? Δ Yes Δ No What?_____ How many per day?_____Since when? _____

Please describe any use of drugs for non-medical purposes:_____

Do you exercise regularly? Δ Yes Δ No Please describe your exercise program: _____

How many hours do you sleep in general?_____ What time do you usually go to bed? _____

Diet How much coffee do you drink?_____cups/day Colas_____number/day Tea_____cups/day

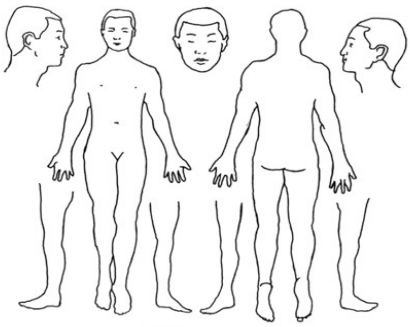
What kind of alcoholic beverages do you usually drink, if any? _____ Average number of drinks/week? _____

How much water do you drink per day? _____

Are you a vegetarian? Δ Yes Δ No Δ Yes, but not so strict Do you eat a lot of spicy food? Δ Yes Δ No

Remarks and additional information (e.g. diet) _____

Indicate pain level and/or painful or distressed areas:



Diagnosis	Self	Family	Diagnosis	Self	Family		Self	Family
Cancer (what type)			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other		

Instructions for Intake Form

Please answer the questions on the following pages as carefully, thoughtfully, and accurately as possible. Many of the questions may not seem directly related to your problem or main complaint, however, each one may help determine which remedy is best suited for you. **All information in this questionnaire is kept confidential.**

The questionnaire is designed to be user friendly. You can answer many of the questions by placing a circle around the appropriate number. For example:

Which weather conditions are you most troubled by?
Circling a number closer to the clear end means that you are more troubled by clear weather. Circling a number closer to the cloudy end means that you are troubled by cloudy weather.

Cloudy Clear
1 2 3 4 5 6 7 8 9 10

Some questions will ask you to rate how much you are troubled by a single particular symptom or how much of this quality characterizes you in general. Circling number "1" means that you are troubled very little while marking "10" means that you are troubled a lot. For example:

Do you worry about any of the following?

Circling closer to "10" means that you worry about your health a lot. Circling closer to "1" means that you do not worry about your health.

1 2 3 4 5 6 7 8 9 10 Health

Some questions ask you to circle the answer you think best fits you. For example:

What are your feelings toward disease?

Optimistic
Doubtful of Recovery Fearful
Despair of Recovery

The following general symptoms pertain to you as a whole person.

Which weather conditions are you most troubled by?

Cloudy Clear
1 2 3 4 5 6 7 8 9 10

Wet Dry
1 2 3 4 5 6 7 8 9 10

Damp cold Snow (Dry Cold) 1
2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10 Storms

1 2 3 4 5 6 7 8 9 10 Wind

1 2 3 4 5 6 7 8 9 10 Fog

1 2 3 4 5 6 7 8 9 10 Hot Sun

Circle which seasons cause you the most trouble?

Winter Spring
Fall Summer

Are you worse being in the:

Mountains At the seashore 1
2 3 4 5 6 7 8 9 10

Are you generally sensitive to and/or troubled by:

1 2 3 4 5 6 7 8 9 10 Bright Light

1 2 3 4 5 6 7 8 9 10 Darkness

1 2 3 4 5 6 7 8 9 10 Open Air

1 2 3 4 5 6 7 8 9 10 Stuffy Rooms

1 2 3 4 5 6 7 8 9 10 Tight Clothing

1 2 3 4 5 6 7 8 9 10 Noise

1 2 3 4 5 6 7 8 9 10 Odors

1 2 3 4 5 6 7 8 9 10 Drafts

Are you generally chilly or warm?

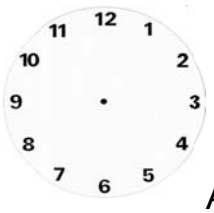
Chilly Warm
1 2 3 4 5 6 7 8 9 10

Which are you generally most sensitive to, warm or cold?

Cold Warm
1 2 3 4 5 6 7 8 9 10

What times of day are you generally worst (mood, energy, symptoms, etc.) What times are you best?

Worst Best



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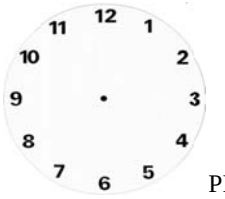

PM

PM

Symptoms during sleep. Circle which you have.

Tooth Grinding
Restlessness Talking
Perspiration Frequent
Urination
Excess Heat or Cold Laughing
Snoring Nightmares
Recurring Dreams
Sleepwalking

Circle what you prefer. Do you sleep:

Without Covers
Partly Covered
Fully Covered (Not including Head)
Fully Covered (Including Head)
With Arms or Legs Out of the Covers
Without Clothing
With a Fan or Air Blowing on You With the Window open

What position do you sleep in most often?

Right Side On Back
Left Side On Abdomen

How much do you perspire?

Never 1 2 3 4 5 6 7 8 9 10 All the Time

Do you have difficulty waking?

Never 1 2 3 4 5 6 7 8 9 10 All the Time

Do you wake unrefreshed?

Never 1 2 3 4 5 6 7 8 9 10 All the Time

Food Desires and Aversions:

In the following questions you are asked how much you desire or are averse to a particular food or taste. Please answer from the point of view of your natural desires, not your knowledge of nutrition. For example, you may never eat fatty meat because this is known to increase cholesterol, however you do love the taste of fat. Answer the question that you like fat. If you strongly desire or crave a food or taste, mark 10. If you detest a food or taste, mark 1.

Tastes:

1 2 3 4 5 6 7 8 9 10	Sweet
1 2 3 4 5 6 7 8 9 10	Sour
1 2 3 4 5 6 7 8 9 10	Salty
1 2 3 4 5 6 7 8 9 10	Bitter
1 2 3 4 5 6 7 8 9 10	Spicy (hot)
1 2 3 4 5 6 7 8 9 10	Smoked
1 2 3 4 5 6 7 8 9 10	Juicy
1 2 3 4 5 6 7 8 9 10	Refreshing
1 2 3 4 5 6 7 8 9 10	Pungent

Foods:

1 2 3 4 5 6 7 8 9 10	Alcohol
1 2 3 4 5 6 7 8 9 10	Apples
1 2 3 4 5 6 7 8 9 10	Bacon
1 2 3 4 5 6 7 8 9 10	Bread alone
1 2 3 4 5 6 7 8 9 10	Bread with butter
1 2 3 4 5 6 7 8 9 10	Butter alone
1 2 3 4 5 6 7 8 9 10	Cheese
1 2 3 4 5 6 7 8 9 10	Chocolate
1 2 3 4 5 6 7 8 9 10	Coffee
1 2 3 4 5 6 7 8 9 10	Pastries
1 2 3 4 5 6 7 8 9 10	Eggs
1 2 3 4 5 6 7 8 9 10	Fat (meat, chicken, pork, etc.)
1 2 3 4 5 6 7 8 9 10	Fish
1 2 3 4 5 6 7 8 9 10	Fruit
1 2 3 4 5 6 7 8 9 10	Fruit (sour)
1 2 3 4 5 6 7 8 9 10	Grain products (pasta, bread, cereal, etc.)
1 2 3 4 5 6 7 8 9 10	Ham
1 2 3 4 5 6 7 8 9 10	Ice
1 2 3 4 5 6 7 8 9 10	Ice cream
1 2 3 4 5 6 7 8 9 10	Indigestible things (chalk, clay, paper, etc.)
1 2 3 4 5 6 7 8 9 10	Lemonade
1 2 3 4 5 6 7 8 9 10	Meat
1 2 3 4 5 6 7 8 9 10	Milk
1 2 3 4 5 6 7 8 9 10	Nut butters
1 2 3 4 5 6 7 8 9 10	Oysters
1 2 3 4 5 6 7 8 9 10	Pickles
1 2 3 4 5 6 7 8 9 10	Vegetables
1 2 3 4 5 6 7 8 9 10	Vinegar

Temperature of food. Which do you prefer?

Warm Food 1 2 3 4 5 6 7 8 9 10 Cold Food

Warm Drinks 1 2 3 4 5 6 7 8 9 10 Cold Drinks

Do you notice any specific tastes in your mouth (e.g., metallic, bitter, foul, etc.)?

How thirsty are you generally?

Not at all Very
1 2 3 4 5 6 7 8 9 10

Mental and Emotional State:

How strong in general are the following emotional symptoms? The most mark 10. The least mark 1.

1 2 3 4 5 6 7 8 9 10 Anxiety (worry and fear)

Do you worry about any of the following? 10 means the most, 1 the least.

1 2 3 4 5 6 7 8 9 10 Creative Activities 1

2 3 4 5 6 7 8 9 10 Emotions

1 2 3 4 5 6 7 8 9 10 Financial Security 1

2 3 4 5 6 7 8 9 10 Health

1 2 3 4 5 6 7 8 9 10 Mental Functioning

1 2 3 4 5 6 7 8 9 10 Morals/past Indiscretions

1 2 3 4 5 6 7 8 9 10 Others (family and close friends) well being

1 2 3 4 5 6 7 8 9 10 Religion

1 2 3 4 5 6 7 8 9 10 Social Life

1 2 3 4 5 6 7 8 9 10 Social Position

1 2 3 4 5 6 7 8 9 10 The Future

1 2 3 4 5 6 7 8 9 10 Work

1 2 3 4 5 6 7 8 9 10 Irresolution (Not being able to decide or stick to a decision)

1 2 3 4 5 6 7 8 9 10 Capriciousness (Willfulness, changeable and erratic desires that are difficult to satisfy)

1 2 3 4 5 6 7 8 9 10 Selfishness

Frightened Easily Never Afraid
1 2 3 4 5 6 7 8 9 10

Answer as honestly as you can about your personality traits.

Stingy Overly generous
1 2 3 4 5 6 7 8 9 10

Thrifty Extravagant
1 2 3 4 5 6 7 8 9 10

Hurried, impatient Slow
1 2 3 4 5 6 7 8 9 10

Messy Fastidious
1 2 3 4 5 6 7 8 9 10

Calm Restlessness
1 2 3 4 5 6 7 8 9 10

Indolence (Lazy) Always busy 1
2 3 4 5 6 7 8 9 10

Shyness/Timid/Bashful Outgoing
1 2 3 4 5 6 7 8 9 10

Anger Mildness
1 2 3 4 5 6 7 8 9 10

Lack of moral sense Guilty
1 2 3 4 5 6 7 8 9 10

No Religious feeling Highly Religious Feeling
1 2 3 4 5 6 7 8 9 10

Obstinate (stubborn) Yielding
1 2 3 4 5 6 7 8 9 10

Heedless/Reckless Cowardice
1 2 3 4 5 6 7 8 9 10

Social/Antisocial. In regard to being with other people or in company?

Aversion Desire for
1 2 3 4 5 6 7 8 9 10

Circle the expression that best describes your feelings about the following issues.

Significant past emotionally traumatic events:

Resolved Grief Dwells
on Past Inconsolable
Remorse
Guilt

Feeling towards people close to you:

Loving
Affectionate
Indifferent
Resentment
Hatred

Feeling toward disease/condition:

Optimistic
Doubtful of recovery
Discouraged Fearful
Despair of recovery

Feeling toward life

Love life
Indifferent
Bored Weary
of life
Loathing of life Desires
death Suicidal thoughts
Suicidal disposition

Feeling toward spouse/lover:

Loving Affectionate
Dissatisfaction
Disappointed
Indifferent
Resentment Hatred

How much do you have the following symptoms? 10 a lot, 1 hardly ever.

1 2 3 4 5 6 7 8 9 10 Irritability

1 2 3 4 5 6 7 8 9 10 Jealousy

1 2 3 4 5 6 7 8 9 10 Mood

Alternating Moods Even Moods
1 2 3 4 5 6 7 8 9 10

Circle which best expresses your general mood.

Morose Sad
Apathy/Indifferent
Excitement Exhilaration

How do you experience sympathy or consolation?

Like Dislike
1 2 3 4 5 6 7 8 9 10

Better from Worse from
1 2 3 4 5 6 7 8 9 10

How talkative are you in general?

Aversion to talking Talkative
1 2 3 4 5 6 7 8 9 10

Not trusting Trusting
1 2 3 4 5 6 7 8 9 10

Gullible Suspicious
1 2 3 4 5 6 7 8 9 10

How often and easily do you weep?

Never Often
1 2 3 4 5 6 7 8 9 10

How often do you experience clairvoyance?

Never Often
1 2 3 4 5 6 7 8 9 10

How is your level of self-confidence?

Lack of confidence Pride/Haughty
1 2 3 4 5 6 7 8 9 10

How impulsive are you?

Never Often
1 2 3 4 5 6 7 8 9 10

How afraid are you of the following? 1, never. 10, very afraid.

1 2 3 4 5 6 7 8 9 10 Animals

1 2 3 4 5 6 7 8 9 10 Being alone

1 2 3 4 5 6 7 8 9 10 Death

1 2 3 4 5 6 7 8 9 10 Relative's Death

1 2 3 4 5 6 7 8 9 10	Impending Disease
1 2 3 4 5 6 7 8 9 10	Downward Motion
1 2 3 4 5 6 7 8 9 10	Evil
1 2 3 4 5 6 7 8 9 10	Failure
1 2 3 4 5 6 7 8 9 10	Falling
1 2 3 4 5 6 7 8 9 10	Ghosts
1 2 3 4 5 6 7 8 9 10	Heights
1 2 3 4 5 6 7 8 9 10	Insanity
1 2 3 4 5 6 7 8 9 10	Misfortune (bad luck)
1 2 3 4 5 6 7 8 9 10	Of a Crowd
1 2 3 4 5 6 7 8 9 10	People
1 2 3 4 5 6 7 8 9 10	Robbers/ Intruders
1 2 3 4 5 6 7 8 9 10	Snakes
1 2 3 4 5 6 7 8 9 10	Spiders
1 2 3 4 5 6 7 8 9 10	Strangers
1 2 3 4 5 6 7 8 9 10	Having a Stroke
1 2 3 4 5 6 7 8 9 10	That something will happen
1 2 3 4 5 6 7 8 9 10	Darkness
1 2 3 4 5 6 7 8 9 10	Thunderstorms
1 2 3 4 5 6 7 8 9 10	Water
1 2 3 4 5 6 7 8 9 10	Wind

Are you forgetful of any of the following?
(1 not at all, 10 a lot)

1 2 3 4 5 6 7 8 9 10	Dates
1 2 3 4 5 6 7 8 9 10	Names
1 2 3 4 5 6 7 8 9 10	Numbers
1 2 3 4 5 6 7 8 9 10	Of what someone else just said to you
1 2 3 4 5 6 7 8 9 10	Of what you just said
1 2 3 4 5 6 7 8 9 10	Of words

How often do you make mistakes with the following?

1 2 3 4 5 6 7 8 9 10	Numbers
1 2 3 4 5 6 7 8 9 10	Words (reading)
1 2 3 4 5 6 7 8 9 10	Words (speaking)
1 2 3 4 5 6 7 8 9 10	Words (writing)

How sensitive are you to any of the following?

1 2 3 4 5 6 7 8 9 10	Beauty
1 2 3 4 5 6 7 8 9 10	Criticism
1 2 3 4 5 6 7 8 9 10	Cruel Stories
1 2 3 4 5 6 7 8 9 10	Frightening things
1 2 3 4 5 6 7 8 9 10	Being made fun of
1 2 3 4 5 6 7 8 9 10	Music
1 2 3 4 5 6 7 8 9 10	Reprimand
1 2 3 4 5 6 7 8 9 10	Rudeness
1 2 3 4 5 6 7 8 9 10	The suffering of others

How do you handle conflict usually?

Quarrelsome Yielding
1 2 3 4 5 6 7 8 9 10

How are you in regard to authority?

Bossy/Dictatorial Yielding/Fawning
1 2 3 4 5 6 7 8 9 10

How critical are you of others?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How critical are you of yourself?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How often do you reproach (find fault, scold, or blame) others?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How often do you reproach yourself?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How honest are you?

Always Lie Always honest 1
2 3 4 5 6 7 8 9 10

How often do you have the following behaviors?

1 2 3 4 5 6 7 8 9 10 Abusive

1 2 3 4 5 6 7 8 9 10 Biting

1 2 3 4 5 6 7 8 9 10 Breaks Things

1 2 3 4 5 6 7 8 9 10 Contrary (Opposite to what is logically expected)

1 2 3 4 5 6 7 8 9 10 Cursing

1 2 3 4 5 6 7 8 9 10 Disobedience

1 2 3 4 5 6 7 8 9 10 Insolent (insult, boldly rude)

1 2 3 4 5 6 7 8 9 10 Rage

1 2 3 4 5 6 7 8 9 10 Rudeness

1 2 3 4 5 6 7 8 9 10 Striking others

1 2 3 4 5 6 7 8 9 10 Striking self

1 2 3 4 5 6 7 8 9 10 Violence

1 2 3 4 5 6 7 8 9 10 Impotence

Please circle the best approximation of your sexual desire. Please circle the level of your desire and not your actual frequency.

Never
1x/year
1x/3 mo.
1x/mo.
2x/mo.
1x/wk.
2x/wk.
4x/wk.
1x/day
2x/day
4x/day

How often do you actually have sex?

Never
1x/year
1x/3 mo.
1x/mo.
2x/mo.
1x/wk.
2x/wk.
4x/wk.
1x/day
2x/day
4x/day

How often do you masturbate?

Never
1x/year
1x/3 mo.
1x/mo.
2x/mo.
1x/wk.
2x/wk.
4x/wk.
1x/day
2x/day
4x/day

What worries or concerns do you have about your sexual life?

Not enough desire Too much desire 10
1 2 3 4 5 6 7 8 9

Not enough sex Too much sex 1
2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10 Lack of enjoyment

1 2 3 4 5 6 7 8 9 10 Difficulty reaching orgasm

1 2 3 4 5 6 7 8 9 10	Troubling fantasies or thoughts
1 2 3 4 5 6 7 8 9 10	Sexual confidence
1 2 3 4 5 6 7 8 9 10	Unusual sexual practices or desires

I have completed this form correctly to the best of my knowledge.

Signature: Δ Adult Patient Δ Parent or Guardian Δ Spouse

Are there any other concerns you want to discuss?

Signature **Date**