

Boosting Fertility Naturally™ Program

Participant Information

Today's Date: _____ Cycle Day (if applicable): _____

First Name: _____

Last Name: _____

Date of Birth: _____

Address: _____

Cell Phone: _____ Work Phone: _____

Email: _____

Emergency Contact Name: _____

Phone Number: _____

Regular Physician: _____

Current Health Information

List of prescription medications: _____

List of supplements: _____

List all allergies: _____

Do you use / consume the following?

Tobacco: _____ How often: _____

Alcohol: _____ How often: _____

Marijuana: _____ How often: _____

Other drugs: _____ How often: _____

Primary Health Concern

Since when: _____

Main symptoms: _____

History — Your Team

List all surgeries with dates: _____

Do any of the following apply to you?

☐ Haemophiliac

☐ Serious heart or lung condition

☐ Wear a pacemaker

☐ Epilepsy

☐ Taking anticoagulant medications

☐ Contagious illness

☐ Cancer

List any disorder you've had in the past: _____

Your Team — Health Care Providers

Name & phone number: _____

Boosting Fertility Naturally™ Program

FIRE

Heart System

- ☐ Do you take a long time to fall asleep
- ☐ Do you toss & turn all night
- ☐ Do you wake up between 1 & 3 am
- ☐ Recurring dreams or nightmares
- ☐ Night sweats – hot at night
- ☐ Do you sweat when anxious
- ☐ Palpitations – chest tightness

METAL

Lung System

- ☐ Shortness of breath
- ☐ Breathing difficulties, asthma
- ☐ Environmental allergies
- ☐ Do you catch colds & flu easily
- ☐ Does it take a long time to recover
- ☐ Any cough, dry or phlegmy
- ☐ Sinus issues, post nasal drip
- ☐ Sleep apnea

Brain Health

Stress level (1=lowest, 10=highest): 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Anxiety level (1=lowest, 10=highest): 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

- ☐ Poor short term memory
- ☐ Poor long term memory
- ☐ Can't retain information
- ☐ Poor focus, poor concentration
- ☐ Worry – overthink – oversensitive
- ☐ Irritable – frustrated – angry
- ☐ Feeling stuck
- ☐ Depressed – sad – feeling blue
- ☐ Can't make decisions
- ☐ Self doubt – low self esteem
- ☐ Envious – jealous of others
- ☐ Difficulty in letting go

Vision & Hearing

- ☐ Tinnitus, high pitch – comes & goes
- ☐ Tinnitus, low pitch – constant
- ☐ Ear pain
- ☐ Ear feeling stuffy
- ☐ Blurred vision
- ☐ Floaters – spots
- ☐ Poor night vision
- ☐ Dry eyes
- ☐ Tearing when windy or crusty eyes
- ☐ Eye twitch
- ☐ Dizziness

Boosting Fertility Naturally™ Program

Female Health

Menarche age: _____ Today is cycle day: _____

Cycle length: _____ Period lasts ____ to ____ days: _____

Blood colour: _____

Flow is: light – medium – heavy – flooding

- ☐ Clots: small – medium – large
- ☐ Cramps: mild – stabbing
- ☐ PMS: tender breasts – bloating – craving – fatigue – low back pain
- ☐ Ovulation pain
- ☐ Intercourse pain
- ☐ Abnormal vaginal discharge
- ☐ Menopause began at ____ years old
- ☐ Night sweats – hot flushes
- ☐ Vaginal dryness

Fertility

- ☐ Birth control
- ☐ Seeing a reproductive endocrinologist

Trying to conceive since: _____

- ☐ Day 3 – Day 21 blood test

Blood test results: _____

Fertility diagnosis: _____

- ☐ IUI – with drugs
- ☐ IVF

WATER

Kidneys / Bladder

- ☐ Dark, scanty urination
- ☐ Dribbling urination
- ☐ Strong smelling urine
- ☐ Frequent, urgent urination
- ☐ Painful urination – burning
- ☐ Bladder incontinence
- ☐ Getting up at night to urinate
- ☐ Premature grey hair
- ☐ Hair loss
- ☐ Wore braces as a child
- ☐ History of broken bone(s)
- ☐ Low bone density
- ☐ Edema of the lower legs

WATER

Temperature

Kidney Yang Deficiency

- ☐ Cold hands
- ☐ Cold feet
- ☐ Cold body
- ☐ Cold nose
- ☐ Loves summer
- ☐ Loves warm foods

Kidney Yin Deficiency

- ☐ Hot palms
- ☐ Hot soles
- ☐ Runs hot
- ☐ Hot at night
- ☐ Loves winter
- ☐ Loves salads
- ☐ Alternates between cold & hot, doesn't like extreme temperature changes

Kidney Qi Deficiency

- ☐ Hair thinning
- ☐ Poor memory
- ☐ Fatigue
- ☐ Low back pain
- ☐ Infertility

Kidney Essence Deficiency

-
- ☐ Poor egg quality
 - ☐ Poor sperm quality
 - ☐ Difficulty conceiving
 - ☐ Low libido
 - ☐ Premature grey hair

Boosting Fertility Naturally™ Program

EARTH

Spleen System

Energy level (1=lowest, 10=highest): 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

- ☐ Mental fatigue
- ☐ Difficulty getting out of bed in AM
- ☐ Not hungry for breakfast
- ☐ Poor appetite
- ☐ Bloating after meals
- ☐ Cravings: sweet – salty – greasy food
- ☐ Food sensitivities

Diet: _____

EARTH

Stomach System

- ☐ Canker sores: mouth – tongue
- ☐ Bad breath – bleeding gums
- ☐ Acid reflux – heartburn
- ☐ Thirst for cold drinks
- ☐ Dry mouth
- ☐ Constant hunger
- ☐ Nausea – vomiting
- ☐ Difficulty digesting fats

Skin Health

- ☐ History of skin issues
- ☐ Acne

Acne location: _____

- ☐ Eczema

Eczema location: _____

- ☐ Psoriasis
- ☐ Greasy skin
- ☐ Dry skin
- ☐ Rashes

METAL

Large Intestine

- ☐ Constipation
- ☐ Straining while having a BM
- ☐ Gas – unfinished feeling after BM
- ☐ Loose stools
- ☐ Diarrhea
- ☐ Smelly diarrhea – blood in stools
- ☐ Urgent, painful diarrhea
- ☐ Alternating diarrhea & constipation
- ☐ Hard, small, dry pebble-like stools
- ☐ Sticky stools
- ☐ Undigested food in the stool

Boosting Fertility Naturally™ Program

WOOD

Headaches

- ☐ Headaches
- ☐ Frontal and orbital
- ☐ Temporal
- ☐ Vertex
- ☐ Occipital
- ☐ Whole head
- ☐ Better with heat
- ☐ Better with rest
- ☐ Better with exercise
- ☐ Better with cold
- ☐ Mild – stabbing – moving pain
- ☐ Migraine
- ☐ Irregular cycles
- ☐ Fibroids / cysts
- ☐ PMS
- ☐ Painful periods

Male Health

- ☐ Low libido
- ☐ Seminal emission
- ☐ Premature ejaculation
- ☐ Erectile dysfunction
- ☐ Prostate hyperplasia
- ☐ Prostatitis
- ☐ Low sperm count – motility
- ☐ Low sperm morphology

Pregnant – how many weeks: _____ Due date:

- ☐ Children
- ☐ C-section

Musculoskeletal

Pain level (1=lowest, 10=highest): 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

- ☐ Constant pain
- ☐ Stiffness
- ☐ Local pain
- ☐ Poor range of motion
- ☐ Better with heat
- ☐ Better with rest
- ☐ Better with massage
- ☐ Comes and goes
- ☐ Swollen
- ☐ Travelling pain
- ☐ Better with cold
- ☐ Better with exercise

Pain location (describe): _____

Boosting Fertility Naturally™ Program

Observation

Constitution (great / average / weak): _____

Body type: _____

Face mapping: _____

Hair: _____ Eyes: _____

Lips: _____ Nose: _____

Nails: _____ Palm: _____

Tongue:

Body colour: _____ Coating: _____

Moisture: _____ Shape: _____

Physical Assessment — Palpation

Pulse (speed):

Blood pressure: _____

Temperature: _____

Skin temperature, 4 limbs: _____

Tender areas: _____

Tender points: _____

TCM Five Element Pattern Recognition

Causes: _____

5 elements: _____

Pattern 1: _____

Pattern 2: _____

Pattern 3: _____

Boosting Fertility Naturally™ Program

Self-Assessed Recommendations & Long-Term Plan Ideas

Recommendations: _____

Long term plan: _____

This form is for educational purposes only and is not to be construed as a healthcare diagnosis or treatment. Please consult your primary healthcare provider for your healthcare and treatment needs.

*Fertility Whisperer™ is a trademark of Way of Wellness Healthcare Inc.
Reformatted with permission from AcuPro Academy*