|  |  |
| --- | --- |
| Full Name and address | DOB/Age |
| Email address | Mobile |
| Occupation | Length of time trying to conceive |
| Date of last appointment |  |
| Relevant Medical/Surgical history |
| Previous Diagnosis |

**Previous or current treatment e.g., IVF, IUI, Medication, Blood tests, Laparoscopy, Semen analysis, General Health**

|  |  |
| --- | --- |
| ***Treatment*** | ***Result or Anticipated date of Treatment*** |
|  |  |

**Current Medications/Chinese herbs or capsules/Supplements/Treatments as recommended by a practitioner or Siobhan**

|  |  |
| --- | --- |
| ***Type of medication/herb/capsule/natural supplement*** | ***Frequency/Dosage*** |
| Medication |  |
| Chinese raw herbs/capsules |  |
| Food supplements/antioxidants/Medicinal mushrooms |  |
| Castor Oil pack/Other |  |
| Meditation/Gratitude Journal/Books/Relaxation |  |

**Woman Menstrual History**

Please give details regarding any ***changes*** you have noticed since starting your treatment plan.

|  |  |
| --- | --- |
| Length of cycle/Consistency/Colour of blood/PMT |  |
| Any other information |  |

**Pregnancy History:** Please give details regarding previous/current pregnancies if any

When, if you conceived easily, if there were complications, outcome of the pregnancy. Miscarriage history

|  |
| --- |
|  |

**Men’s Semen History**

Please give details regarding any ***changes*** you have noticed since starting your treatment plan.

|  |  |
| --- | --- |
| Fluid consistency/Viscosity/Colour/Odour |  |

**General changes since your last appointment**

Please note any changes you have noticed since you started your treatment plan. This will greatly assist us when re-prescribing herbs/capsules and natural supplements.

|  |  |
| --- | --- |
| Digestive System |  |
| Hot/Cold |  |
| Stress levels |  |
| Any other information |  |