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**Download this form to your computer
 to be able to submit by email.
 Click the submit button at the bottom
 when you are done and follow prompts.**

Men's Health Assessment:

Name _____

Date _____

Please answer the following to the best of your ability.

We appreciate your responses in creating a complete, holistic health assessment.

Place a **"C"** in front of all that applies to your **CURRENT** state of health

Place a **"P"** in front of all that applies to your **PAST** health history

- Sleep disturbances/Insomnia Upper back pain Lower back pain Shoulder pain Neck pain
- Elbow pain Wrist/hand pain Ankle/foot pain Headaches Hip pain Rib pain Chronic body pain
- Knee pain High stress Depression/Anxiety Dry eyes Dry skin/hair Dry throat Hernia(s)
- Thinning hair Poor vision Anemia Digestive complaints Nausea Constipation Diarrhea
- History of surgeries History of major illness(es) Frequent urination Scanty urination Crave sweets/salty
- Blood in urine Frequent UTI Low appetite Shortness of breath Asthma High BP Palpitations
- High cholesterol Ear ringing Poor hearing Dizziness Chest pain/tightness Thyroid disorder
- Night sweats Day sweats Low libido Excessive hunger/thirst BPH Infertility Fatigue/energy crashes
- Abnormal PSA Skin conditions STD Gallstones Erectile dysfunction Varicocele Testicular trauma
- Testicular infection Allergies Asthma Cold hands & feet Chronic infections Frequent nightmares
- Tendency to feel too warm/hot Fatigue/low energy Irritability/rage Frequent colds/flu

***Please briefly list ANY MAJOR MEDICAL EVENTS: surgeries, illnesses with Age/Date at which it (they) occurred on this form. If there is not enough space, please continue the list on the back of the form.**

***Please briefly describe your vision of optimal health:**

*Are you interested in taking herbs/supplements? Yes No

*Are you interested in receiving seasonal newsletters/coupons/email specials? Yes No

digital signature