A D A G I O H O L I S T I C T H E R A P I E S , L L C
612-288-0488 www.adagioholistic.com

CLIENT HEALTH HISTORY
FOR MEN ONLY

Urinary Symptoms

Circle and describe those symptoms as applicable:

painful urination bladder/kidney infections frequent urination incomplete urination

Nocturnal (night time) urination frequency, how many times per night? _____

Changes in urinary stream (describe flow, stream, strength of stream, color) _____

_____

When did you first notice these symptoms? _____

Are they getting better or worse? _____ Describe _____

Reproductive Health History:

Circle and describe those symptoms as applicable:

Headaches (migraine, tension, cluster) Numbness in legs/feet Sore heels

Low back pain Anxiety Irritability Depression

Varicose veins ____ location _____

Symptom explanations: _____

Is there a history of **back injury/trauma**? _____ If so, describe

_____

_____

When did you first notice these symptoms? _____

Are they getting better or worse? _____ Describe _____

Circle and describe as applicable:

difficulty obtaining an erection painful ejaculation difficulty maintaining an erection

Have you had a **PSA test** (Prostate Specific Antigen)? _____ Date _____

Results _____

Have you had a **sperm analysis test**? _____ Date _____

Results _____

Additional comments _____

History of **sexually transmitted diseases**? _____ when?

_____

Type/treatment?_____

Family history of **cancer**? _____ type? _____

Relationship to you: _____

Family history of **prostate disease**? _____ type?

_____

Relationship to you: _____

Rate your interest in sex: HIGH MODERATE LOW NONE

Do you have pain with orgasm? _____

Do you have, or ever had, difficulty experiencing orgasms? _____

Have you every had a fall or injury to your low back, sacrum, tailbone?

_____

Have you experienced a history of: rape? ____ trauma? ____ incest? ____

If so, when? _____

Did you undergo counseling for this? ____ If so, did/do you find this helpful?

_____

Fertility

Have you ever had a vasectomy? _____ Date _____

Have you had a vasectomy REVERSAL? _____ Date _____

What method(s) of birth control have you used? _____

Have you conceived in the past? _____

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

Please check as applicable. Do you:

____ wear tight fitting underwear or clothing?

____ take steam baths, saunas, and/or whirlpools?

____ spend time on machinery that would make the testicles hot?

____ use SEAT warmers in the car/truck?

____ do you have varicosities of the scrotum?

Please list any medications and or supplements you are currently taking or have taken within the last 3 months _____