



## Pulling Down the Moon Acupuncture Intake Form

\_\_\_\_\_  
First Name (print) Last Name Today's Date

\_\_\_\_\_  
Address City State Zip

[ \_\_\_\_\_ ] \_\_\_\_\_  
Emergency Contact Phone# Your Occupation/Employer

\_\_\_\_\_  
Email Phone# Ht Wt Sex Age Birth Date

Primary Care Physician Name and practice location \_\_\_\_\_

OB/GYN or Urologist Name and practice location \_\_\_\_\_

Reproductive Endocrinologist Name and practice location \_\_\_\_\_

How did you hear about us? (doctor, nurse, friend, website, flyer) \_\_\_\_\_

In case of a Press Event, would you be willing to share your story? Yes No

If YES, please check which of the following we could contact you about: Print Interview T.V. Radio Testimonial

### Health History

What are the health problems for which you are seeking treatment?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had this condition?

What other forms of treatment have you sought?

Please list any surgeries or major health incidents (accidents, etc.) in your life:

\_\_\_\_\_  
\_\_\_\_\_

Please summarize your daily diet:

\_\_\_\_\_  
\_\_\_\_\_

Indicate the use and frequency of the following:

Tobacco \_\_\_\_\_

Alcohol \_\_\_\_\_

Coffee \_\_\_\_\_

Soda pop \_\_\_\_\_

Water \_\_\_\_\_

Family Medical History:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Emotions:**

- Normal  Problem
- Depression  Sadness  Panic attack  Sensitive
- Worries  Overly excited
- Anger  Anxiety

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Energy:**

- Normal  Problem
- Low  Up and down  Exhausted  Hyperactive
- Nervous energy  Abundant

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Sleep Pattern:**

- Normal  Insomnia
- Falling Asleep:  Sometimes Difficult  Always difficult
- Sometimes very difficult  Always very difficult
- Sleep in daytime  Take naps
- Waking up: \_\_\_ Times per night  Wake up too early
- Wake up at night and cannot go back to sleep again

**Sleep Quality:**

- Deep  Light  Bad
- Many dreams  Bad dreams  Grinding teeth  Talking in sleep  Other

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Temperature:**

- Normal  Abnormal
- Feel cold easily  Cold Hands  Cold feet  Alternating hot and cold
- Feel hot easily  Hot flash  Sensitive to weather changes

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Sweating:**

- Normal  Abnormal
- Too easily  Too much  Difficult  Too little  Night Sweats  Other

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Sensitivity and Allergies:**

- No  Yes
- Cold  Hot  Dampness  Light  Noise
- Airborne particles  Food  Drugs  Other

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Appetite and Digestion:**

- Normal  Abnormal
- Rapid Hungering  Poor appetite  Nausea  Anorexia
- Bloating  Gas
- Hungry, but no desire to eat  Other

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Bowel Movement:**

- Normal  Abnormal Time of day: \_\_\_\_\_
- Constipation  Diarrhea  Loose  Watery
- Incomplete  Hard and Dry
- Strong Smell  With mucous  With blood  Other

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Body Weight:**

- Normal  Overweight  Underweight

**If overweight:**

How many pounds would you like to lose? \_\_\_\_\_  
 How many years ago did you first start to gain weight?  
 \_\_\_\_\_

Are you following a weight control program at this time? \_\_\_\_\_

Describe: \_\_\_\_\_  
 \_\_\_\_\_

**Drinking:**

- Normal  Abnormal
- Thirsty  Dry Mouth  Drink a lot  Dry mouth but no desire to drink
- Not thirsty but drink a lot anyway

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Urination:**

- Normal  Abnormal
- Frequent  Urgent  Burning  Painful  Cloudy  Dark Color
- Foul smell  Bloody  Difficult  Retention

Number of times per day \_\_\_\_\_ Number of times per night \_\_\_\_\_ Other \_\_\_\_\_  
 Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Lifestyle:**

- Alcohol  Tobacco  Marijuana  Drugs  Occupational Hazards

Regular exercise: Type \_\_\_\_\_  
 Frequency \_\_\_\_\_  
 Type \_\_\_\_\_ Frequency \_\_\_\_\_



## Menstrual History

Age at which Menses Began \_\_\_\_\_  
Age at which it stopped \_\_\_\_\_  
Are your periods painful?  Yes  No  
How many days does the pain last? \_\_\_\_\_  
How many days do you normally bleed? \_\_\_\_\_  
How heavy is the bleeding?  Light  Normal  Heavy  
What color is the blood?  Light red  Red  Dark Red  
 Brown  Black  
Is there clotting?  Yes  No  
Do you have premenstrual tension?  Yes  No  
Does your face break out before or during your period?  
 Yes  No  
Do your breasts become tender premenstrually?  
 Yes  No  
Do you retain water during your period?  Yes  No  
Do you bleed or spot between periods?  Yes  No  
Are your menstrual cycles spaced irregularly?  Yes  No  
How many days are there from one period to the next?

\_\_\_\_\_  
Date of last menstrual period

### Number Years

How many pregnancies have you had? \_\_\_\_\_  
How many children do you have? \_\_\_\_\_  
How many abortions have you had? \_\_\_\_\_  
How many miscarriages have you had? \_\_\_\_\_  
How many times has a D&C been performed?

### Complications?

\_\_\_\_\_  
Have you ever had an abnormal pap smear?  
 Yes  No  
Have you ever had a cervical biopsy, operation,  
cauterization or conization?  Yes  No  
Have you ever had a venereal disease?  Yes  No  
Do you get yeast infections regularly?  Yes  No

Have you ever been diagnosed with a chlamydial  
infection?  Yes  No

Do you have chronic vaginal discharge?  Yes  No

Do you have any sores on your genitalia?  Yes  No

Have you ever had pelvic inflammatory disease?  
 Yes  No

Were you treated for it?  Yes  No

How? \_\_\_\_\_

\_\_\_\_\_  
Date of last Pap smear \_\_\_\_\_

Have you ever been diagnosed with uterine fibroids or  
polyps?  Yes  No

Have you ever been diagnosed with endometriosis?  
 Yes  No

Have you been diagnosed with pelvic adhesions?  
 Yes  No

Have you been diagnosed with any pelvic  
abnormalities?  Yes  No

Have you taken any medications other than  
contraceptives for gynecological conditions? \_\_\_\_\_

| <u>Medicine</u> | <u>Reason</u> | <u>How Long</u> |
|-----------------|---------------|-----------------|
|-----------------|---------------|-----------------|

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
|-------|-------|-------|

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
|-------|-------|-------|

Have your cycles changed since they began?  Yes  No  
How? \_\_\_\_\_

\_\_\_\_\_

Do you ovulate on your own?  Yes  No  
On what day of your cycle?

\_\_\_\_\_  
Do your breasts get tender at/during ovulation?  
 Yes  No

Do you get premenstrual low back pain?  Yes  No

Do your bowel movements become loose at the  
beginning of your period?  Yes  No



## Fertility History

How long have you been trying to conceive?

Is there a history of infertility in your family?

Yes No

Describe: \_\_\_\_\_

Have you had fertility treatments? Yes No

If yes, when and where? \_\_\_\_\_

By whom? \_\_\_\_\_

What types? \_\_\_\_\_

Have you taken medication to help you ovulate?

Yes No

When? \_\_\_\_\_ How long? \_\_\_\_\_

Have your fallopian tubes been evaluated medically?

Yes No

What were the results?

Have you had any tubal operations? Yes No

Have you had any hormone laboratory tests performed?

Yes No

What were the results?

Do you have a single partner with whom you have been trying to conceive?

Yes No

How long have you been married or living together?

Has he had a fertility workup? Yes No

What were the results?

Is your partner supportive of your wish to conceive?

Yes No

Have you taken oral contraceptives? Yes

No

When?

How long? \_\_\_\_\_

Have you ever had an IUD? Yes No

When?

How long? \_\_\_\_\_

Have you ever taken DepoProvera? Yes

No

When?

How Long? \_\_\_\_\_

Have you had a diagnosis relating to infertility?

Yes No

What was it? \_\_\_\_\_

How is your sexual energy? Low

Normal High

Are you experiencing any sexual problems?

Yes No

Does your partner experience any sexual dysfunction?

Yes No

Do you douche regularly? Yes No

With what? \_\_\_\_\_

Do you use vaginal lubricants? Yes No

Are you more than 20% over your ideal body weight?

Yes No

Are you more than 20% below your ideal body weight?

Yes No

Do you have a stressful occupation? Yes No

Do you exercise regularly? Yes No

Do you have excessive facial hair? Yes No

Do you have excessively oily skin? Yes No

Have you experienced excessive loss of head hair?

Yes No

Have you noticed discharge from your nipples?

Yes No

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? Yes No

Have you been exposed to any known environmental toxins or hormones? Yes No

Are you presently taking steroids? Yes No