



Acupuncture Intake Form

(please print)

First & Last Name Today's Date

Street Address City State Zip

Phone Number Email Address Ht Wt Sex Age Date of Birth

Your Occupation/Employer Emergency Contact (Name & Phone Number)

Primary Care Physician (Name, Practice, Location)

OB/GYN or Urologist (Name, Practice, Location)

Reproductive Endocrinologist (Name, 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 TV 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 (year and type)

Please summarize your daily diet

Family Medical History

Sleep Pattern: Normal Insomnia
Falling Asleep: Sometimes Difficult Always Difficult
Wake up _____ times per night Wake Up Too Early
 Wake up at night and cannot go back to sleep
 Sleep in Daytime Take Naps
Sleep Quality: Deep Light Bad Many Dreams
 Bad Dreams Grinding Teeth Talking in Sleep
 Other, Describe _____

Energy: Normal Problem Low Up & Down
 Exhausted Hyperactive Nervous Abundant
 Other, Describe _____

Appetite and Digestion: Normal Problem Rapid
Hungering Poor Appetite Nausea Eating Disorder
 Bloating Gas Hungry, but no desire to eat
 Other, Describe _____

Drinking: Normal Problem Thirsty Dry Mouth
 Drink a Lot Dry Mouth, but no desire to drink
 Not Thirsty, but drink a lot anyway
 Other, Describe _____

Bowel Movement: Normal Problem
Time of day _____ Constipation Diarrhea
 Loose Watery Incomplete Hard & Dry
 Strong Smell Mucous Bloody
 Other, Describe _____

Urination: Normal Problem Frequent Urgent
 Burning Painful Cloudy Dark Color Foul Smell
 Bloody Difficult Retention
Number of times per day _____, per night _____
 Other, Describe _____

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 _____

Sweating: Normal Problem Too Easily
 Too Much Difficult Too Little Night Sweats
 Other, Describe _____

Temperature: Normal Problem Cold Hands
 Cold Feet Alternating Hot/Cold Sensitive to
Weather Changes Feel Cold Easily Feel Hot Easily
 Hot Flashes
 Other, Describe _____

Emotions: Normal Problem Depression
 Sadness Panic Attack Sensitive Worries
 Overly Excited Anger Anxiety
 Other, Describe _____

Sensitivity/Allergies: No Yes Cold Hot
 Dampness Light Noise Airborne Particles
 Food Drugs
 Other, Describe _____

Lifestyle:
 Regular exercise, Type _____
Frequency _____

Indicate the use and frequency of the following:

Tobacco _____ Alcohol _____
Water _____ Coffee _____
Soda Pop _____

Menstrual History

Age menses began _____ Age menses stopped _____

Are your periods painful? Yes No

If so, how many days does the pain last? _____

How many days do you typically bleed? _____

How heavy is the bleeding? Light Moderate 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 you have premenstrual breasts tenderness?

Yes No

Do you retain water during your period? 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

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 _____

Have your cycles changed since they began? Yes No

Describe _____

Do you ovulate on your own? Yes No

On what day of your cycle? _____

Do your breasts get tender at/during ovulation?

Yes No

Date of last Pap smear _____

Have you ever had an abnormal pap smear?

Yes No

Have you ever had a cervical biopsy, operation, cauterization or conization? Yes No

Number & Years:

Pregnancies _____

Children _____

Abortions _____

Miscarriages _____

D&Cs _____

Complications _____

Have you ever had a venereal disease? Yes No

Do you get yeast infections regularly? Yes No

Have you ever been diagnosed with Chlamydia? 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

Treatment method _____

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/abnormalities?

Yes No

Have you been diagnosed with PCOS (Polycystic Ovary Syndrome)?

Yes No

Have you taken any medications other than contraceptives for gynecological conditions? Yes No

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

Results? _____

Have you had any tubal operations? Yes No

Have you had any hormone laboratory tests performed?

Yes No

Results? _____

Do you have a single partner with whom you have been trying to conceive? Yes No

Is your partner supportive of your wish to conceive?

Yes No

How long have you been partners? _____

If Male, has he had a fertility workup? Yes No

Results? _____

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 Depo-Provera? Yes No

When? _____

How long? _____

Have you had a diagnosis relating to infertility? Yes No

What was diagnosis? _____

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 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) while 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