Natural Fertility Center of Pennsylvania
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Acupuncture New Patient Intake Form

Name _____

Home Phone _____

Address _____

Email Address _____

Occupation _____

Emergency Contact _____

Referred by: _____

Have you ever had acupuncture (circle one) Yes No

Are you currently under the care of a physician? If so, who and for what conditions?

Main Reason(s) for seeking treatment?

How long have your experienced symptoms?

List all current medications, prescribed or otherwise, including vitamins & supplements

Date of Birth _____

Do you have high blood pressure? Yes or No Are you on medication Yes or No

Do you have pace maker or other device or hardware in the body? Yes or No

Significant illnesses (please check all that apply)

- ◯ **Cancer**
- ◯ **Hepatitis**
- ◯ **Stroke**
- ◯ **HIV/ Aids**
- ◯ **Tuberculosis**
- ◯ **Thyroid**
- ◯ **Stomach Ulcers**
- ◯ **Depression**
- ◯ **Chronic Fatigue**
- ◯ **Diabetes**
- ◯ **Heart Disease**
- ◯ **Seizures**
- ◯ **Pneumonia**
- ◯ **Multiple sclerosis**
- ◯ **Asthma**
- ◯ **Obesity**
- ◯ **Shingles**
- ◯ **Rheumatic Fever**

For the next three choices, please list details below…..

Surgery (Dates and type)

Major Trauma (emotional or accidental; describe)

Allergies- Please List

Lifestyle (Please Check all that apply and note frequency of use)

- ◯ Tobacco
- ◯ Alcohol
- ◯ Recreational drugs
- ◯ caffeinated beverages.

Exercise- Please list types of activity and frequency

Emotional Stress (Please Circle)

1	2	3	4	5	6	7	8	9	10
No Stress				Moderate					Extremely Stressed

General Symptoms (Check all that apply)

◯Fatigue
◯Night Sweats
◯ Dizziness/ Vertigo
◯ Sweat without exertion
◯ Fever/Chills
◯Bleed/ Bruise Easily

Digestion (Check all that apply)

◯Extreme Appetite
◯ Craving
◯ Tired after eating
◯ Gas
◯ Vomiting
◯ Irritability or low energy between meals
◯ No Appetite
◯ Dieting
◯ Bloating
◯ Nausea
◯ Bulimia

How many meals per day? _____
How many Snack per day? _____

Gastrointestinal (Check all that apply)

◯ Diarrhea
◯Hemorrhoids
◯ Laxative Use
◯ Mucous in stool
◯ Intestinal Pain/Cramping
◯ Irritable Bowel Syndrome
◯ Gout
◯ Constipation
◯ Anal itching/ burning
◯ Bloody Stool
◯ Anal Fissures
◯ Incomplete Evacuation
◯ Colitis
◯ Gall Stones

Head Ears, Eyes, Nose, Throat (Check all that apply)

◯ Dry Eyes
◯ Blurred Vision
◯ Eye Strain
◯ Cataracts
◯ Bleeding Gums
◯ Sores on tongue or mouth
◯ Excess Saliva
◯ Post Nasal drip
◯ Headaches or Migraines
◯ Difficulty Swallowing
◯ Tinnitus/ ringing
◯ Nosebleed
◯ Spots Flowery Vision
◯ Poor Vision
◯ Night blindness
◯ Macular degeneration
◯ TMJ
◯ Dry Mouth
◯ Sinus problems
◯ Sore throat
◯ Swollen Glands
◯ Bloody Stool
◯ Ear Aches
◯ Deafness

Cardiovascular/ Respiratory (Check all that apply)

◯ Heart Palpitations
◯ Difficulty Breathing
◯ Varicose Veins
◯ Swollen Ankles
◯ Shortness of Breath
◯ Dry Cough
◯ Chest Tightness
◯ Difficult Exhalation
◯ Chest Pains
◯ High Cholesterol
◯ Blood Clots
◯ Heart Valve Abnormality
◯ Cold Hands/ Feet
◯ Wheezing
◯ Difficult Inhalation
◯ Productive Cough (color?)

Skin/Hair (Check all that apply)

◯ Dry skin
◯ Eczema
◯ Pimples/ Acne
◯ Brittle Nails
◯ Hair Loss
◯ Rashes/ Hives
◯ Psoriasis
◯ Fungal Infection
◯ Ridged Nails
◯ Dandruff

Musculoskeletal (Check all that apply)

◯ Spin Pain
◯ Tendonitis
◯ Arthritis
◯ Vertebral Disc degeneration
◯ Numbness
◯ Joint Pain
◯ Swelling
◯ Limited Range of Motion
◯ Osteoporosis
◯ Carpal tunnel

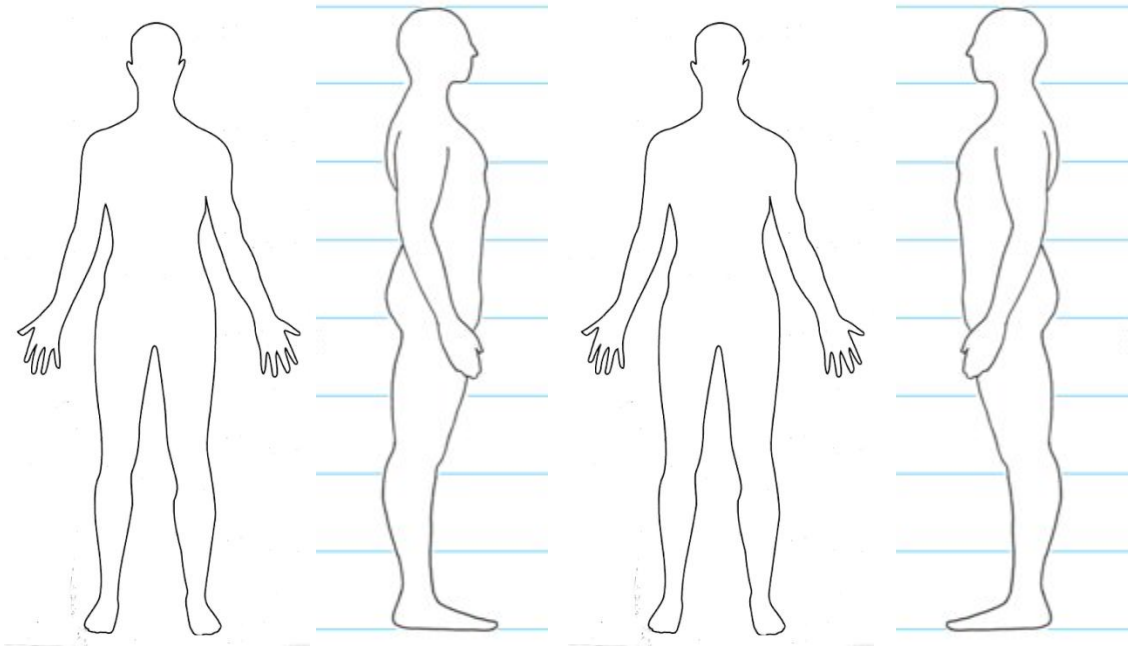
Neuropsychological (Check all that apply)

◯ Anxiety
◯ Insomnia
◯ Easily Stressed
◯ Seasonal Mood Disorder
◯ Tremors
◯ Job Stress
◯ Death of Someone Close
◯ Irritability
◯ Depression
◯ Poor Memory
◯ Tics
◯ Currently in Therapy
◯ Recent Divorce
◯ Financial Set Back

Genito- Urinary (Check all that apply)

◯ Frequent Urination
◯ Incomplete Urination/ retention
◯ Burning Urination
◯ Wake Frequently to Urinate
◯ Bedwetting
◯ Impotency
◯ Loss of Urine when laughing or sneezing
◯ Dribbling
◯ Blood in Urine
◯ Kidney Stones
◯ Decreased Libido
◯ Infertility

Please indicate with an X on the drawing your areas of discomfort, especially areas of tension



Front Right Back Left

Fertility Health History

1. Pregnancy History
   Time of Pregnancy _____ Live Birth _____ Miscarriage_____
   Abortions_____

2. **Menstrual History**

   Age of first period _____

   Date of last two menstrual periods _____ & _____

   Are your periods regular? (Yes or No) Do you have a history of irregular periods? (Yes or No)

   What is the duration of your cycle? _____ How long do your periods last? _____

   Premenstrual Symptoms (Circle those that apply)

   Headache Breast Tenderness Mood Swings Depressions Constipation
   Diarrhea Fatigue Bloating Cramps Back Pains Spotting
   Others: _____

   Do you have or had any of the following? (Please Circle)

   Hot Flashes/Flushes Abnormal vaginal discharge Stop and Start Flow Clotty Periods
   Fibroids Uterine Masses Endometriosis PCOS Ovarian Cyst
   STD's Recurrent Virginities Other; _____

3. **History of Fertility Therapies (Fill out if applicable)**

   How long have you been currently trying to conceive? _____
   Have you been treated for infertility previously? _____
   Was the infertility diagnosed? _____
   What drugs have you take for infertility? (Circle all that may apply)
   Clomid Gonal F Follistim Repronex Pergonal Fertinex
   HCG Profasi Progesterone Lurpon Antagon Parlodel Heparin
   Baby Aspirin Oral Contraceptives Others: _____

   Male Factor Fertility?

   Have you seen an urologist for infertility? _____
   What was the diagnosis? _____
   Any reproductive Surgeries? _____
   Any concern with sperm count or morphology, motility, etc? _____

Have you ever undergone Artificial Insemination (IUI) or In Vitro Fertilization (IVF)?
(Yes or No)

If Yes, partner or donor sperm? _____

Donor Eggs? _____

Clomid? _____ Fertility Shots/Injections? _____

Of IUI's _____ Dates_____

Of IVF's _____ Dates_____

Have you had any of the following tests? If so please explain results;

Hormonal Assays (FSH, LH, Prolactin, Estradicol, DHEA-s, Test, Prog)

_____

Endometrial Biopsy

_____

Hysterosalpinogram

_____

Sonohystrogram

_____

Ultrasound

_____

Laparoscopy, hysteroscopy

_____

Thyroid Test

_____

Genetic Screening

_____

Antisperm Antibodies

_____

Varicocele Repair

_____

Other

Are you working with a Reproductive Endocrinologist now? If so, which doctor and office?

_____

What are your future plans with fertility treatments?

_____

Have you ever had acupuncture to treat infertility?

_____

Have you ever taken herbs for infertility? If so, please list.

_____

Informed consent

Acupuncture is a technique in which sterile, stainless steel disposable needles are inserted into specific points on the body to cause a desired healing effect via regulating the flow of Qi out by Chinese over 3,000 years ago. Techniques may include manual stimulation of the needless, electro-acupuncture, cupping, and moxibustion. The benefits of acupuncture may include alleviation of pain or other symptoms, an overall sense of well being, improved sleep, and increased energy levels.

Risk may include feeling weak, nauseated, faint, or bruising at the site of the needle insertion and worsening of symptoms can occur after treatment. These risks are rare, but not unreported. Most symptoms are usually related to anxiety. Taking deep breaths and trying to relax helps. Do not hesitate to speak up if you are overly nervous or have concerns.

Other important things to keep in mind;

- **While the needles are in place do not change your position too much or move suddenly.**
- **Wear comfortable, loose fitting clothing.**
- **Avoid treatments when excessively fatigued, hungry, or overly full.**
- **We are unable to treat patients who are intoxicated and/or abusing substances.**
- **Try to refrain from strenuous activity for 1-2 hours following treatment.**

Please provide 24 hour notice to cancel an appointment. If less than 24 hr notice is given, it is up to the discretion of the office staff to charge a cancellation fee. If the cancellation policy is violated regularly you may be asked to pre-pay for future visits.

At times, feel comfortable to discuss any questions or concerns you may have.

With this knowledge, I voluntarily consent to have acupuncture treatments.

_____ Date _____

I have read and understand the above statement
Signature of Patient