aim acupuncture & integrative medicine

New Patient Intake – Fertility Female

Today's Date: _____/_____/_____

General Patient Information: (*All information provided is held strictly confidential--see permission to share medical information section*)

Last Name: _____ First Name: _____
Home Phone: _____ Cell: _____ Email: _____
Work Phone: _____ Occupation: _____

Street Address: _____
City: _____ Zip Code: _____

Birth Date: _____/_____/_____ Age:_____ Height: _____ Weight: _____
Marital Status: ___Single ___Married ___Partnered ___Separated ___Divorced ___Widowed
Spouses Name: _____ Age: _____ Occupation: _____

In case of Emergency, who should we contact?: _____
Relationship: _____ Phone Number: _____

How did you hear about us? _____
Reason for your visit today: _____
How long have you had this condition?_____ Is it getting worse? Yes No
Does it affect your: Sleep _____ Work _____ Other _____
What seemed to be the initial cause? _____
What seems to make it better?_____
What seems to make it worse?_____
Are you under a physician's care now? NO YES For what? _____

Please give us the name & phone number of your:
Physician: _____
OB/GYN: _____
Reproductive Endocrinologist: _____
Reason you decided to try acupuncture & Oriental medicine? _____
How long did you think about it before you made your appointment? _____
Have you had acupuncture before? YES NO Chinese Herbal Medicines? YES NO
Surgeries: (include dates) _____ _____
_____ _____
Allergies: _____

I hereby give my consent for treatment by Denise Noyer-Erez, L.Ac., and Associates.
I accept full financial responsibility for all medical services performed on my behalf.

_____ _____
Patient Signature Parent/Guardian Signature

Family Medical History: *(Please check any and all condition(s) members of your family have had)*

Illness:	Father	Mother	Sibling(s)	Grandparents	Aunt/Uncle
Cancer	____	____	____	____	____
Diabetes	____	____	____	____	____
High Blood Pressure	____	____	____	____	____
Heart Disease	____	____	____	____	____
Allergies	____	____	____	____	____
Drug Abuse	____	____	____	____	____
Alcoholism	____	____	____	____	____
Mental Illness	____	____	____	____	____
Seizures	____	____	____	____	____
Strokes	____	____	____	____	____
Other: _____	____	____	____	____	____

General Health Information:

Major Health Complaints and/or Symptoms:

1. _____
2. _____
3. _____

Please explain how these conditions affect or impair your daily activities:

_____

_____

Describe your symptoms when they are at their worst:

_____

_____

What makes your symptoms better?

_____

_____

Are there any other complaints or conditions that you would like us to know about?

_____

_____

Please list any non-prescription drugs or recreational drugs you currently take:

_____

_____

Medical Conditions/History: *(Circle any conditions you have had, or are currently experiencing)*

Aids/HIV	Cancer	Hepatitis	Osteoporosis	Stroke
Alcoholism	Diabetes	Herpes	Pacemaker	Thyroid Disorder
Allergies	Emphysema	Lyme Disease	Pneumonia	Tuberculosis
Appendicitis	Epilepsy	High Blood Pressure	Polio	Typhoid Fever
Arteriosclerosis	Goiter	Measles	Rheumatic Fever	Ulcers
Arthritis	Gout	Menopause	Scarlet Fever	Venereal Disease
Asthma	Heart Disease	Multiple Sclerosis	Seizures	

Gynecological History:

Age at your first period: _____
The first day of your last period? _____
Are your periods regular? YES NO Explain: _____
Number of days between periods: _____
Number of days of bleeding: _____
Amount of bleeding? (*circle one*) LIGHT - - - - MEDIUM - - - - HEAVY
What color is the blood? PURPLE BROWN BLACK BRIGHT RED PINK
Is there clotting? YES NO
Do you bleed or spot between periods? YES NO
Have you ever taken medication to bring on your period? YES NO
Do your breasts become tender pre-menstrually? YES NO
Do you have pre-menstrual low back pain? YES NO
Do you have pain with menstruation? YES NO
Degree of pain: MILD - - - MODERATE - - - SEVERE
Pain relieved by over-the-counter medications? YES NO
Does the pain start with the onset of bleeding? YES NO
Begin before the onset of bleeding? YES NO
Persist more than 48 hours? YES NO

Do you ovulate on your own? YES NO
Do you experience pain during ovulation? YES NO
On which day of your cycle do you ovulate? _____
Do you have vaginal discharge? YES NO
Associated with itching or burning? YES NO
Associated with unusual odor? YES NO
Do you get yeast infections? YES NO
Do you experience pain during intercourse? YES NO
Is the pain mostly external? Or internal ? _____

Do you have a gynecologist? YES NO
Name and location of gynecologist:_____
When was your last pap smear? _____ Result? _____
Have you ever had an abnormal pap? YES NO
If yes, what follow up was necessary_____
Have you ever had a mammogram? YES NO

Have you ever had a sexually transmitted disease?
Chlamydia, HPV, Gonorrhea, Herpes, Other: _____
When? _____ Was it treated? _____

Do you experience milk or other discharge from your nipples? YES NO
Have you ever used an IUD? YES NO
Have you ever used the Oral Contraceptive Pill YES NO
If yes, for how long? _____ When did you last use it? _____
How long did it take for your menses to regulate? _____

Please indicate number of:

___ Pregnancies ___ Premature Births
___ Children ___ Ectopic Pregnancies
___ Miscarriages ___ IVF's - How many successful (date) _____ Unsuccessful (date) _____
___ Abortions ___ IUI's - How many successful (date) _____ Unsuccessful (date) _____

Previous Gynecological Surgeries: **Date of Procedure**

C-Section Births _____
Dilation & Curettage (D&C) _____
Hysterosalpingogram (HSG) _____
Hysteroscopy _____
Laparoscopy _____
Other: _____

Previous Diagnostic Assessments: *(please check all that apply)*

__ Advanced Maternal Age
__ Amenorrhea
__ Anovulation
__ Cervical Stenosis
__ Elevated FSH
__ Endometriosis (mild, moderate, severe)
__ Fallopian Tube Blockage
__ Habitual Miscarriage
__ Hostile Cervical Mucus
__ Hyperprolactinemia
__ Luteal Phase Defect
__ Menorrhagia
__ Ovarian Cyst
__ Ovarian Hyperstimulation Syndrome (OHSS)
__ Pelvic Adhesions
__ Pelvic Inflammatory Disease (PID)
__ Phospholipid Antibodies
__ Polycystic Ovarian Syndrome (PCOS)
__ Premature Ovarian Failure
__ Unexplained Infertility
__ Uterine Fibroids or Polyps
__ Other: _____

List any fertility drugs you have taken:
_____
_____

Medications you use currently: _____
_____

Do you use tobacco? Yes _____ No _____ # Packs/day _____
Do you use alcohol? Yes _____ No _____ # Drinks/wk _____

How long have you been trying to get pregnant? _____

Have you had a fertility workup? YES NO
What were the results? _____

How is your sexual energy? Low Normal High
Do you use vaginal lubricants? YES NO

Do you have a stressful occupation? YES NO
Do you exercise regularly? YES NO
How often? _____

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

Male Factor:
Semen Analysis: Date:_____Count:_____Morphology:_____Motility:_____Volume:_____

Overall Symptoms: *(Please circle any of the following symptoms that currently pertain to you)*

Body Temperature (Kidney & Organ System)

Cold hands	Hot body temperature	Profuse perspiration	Perspire easily
Cold feet	Cold body temperature	Lack of perspiration	Cold hips/buttocks
Sweaty palms	Afternoon Flushing	Night sweating	Incontinence
Sweaty feet	Hot Flashes	Strong thirst	Night time urination

Low back weakness or pain	Vaginal dryness
Fertile cervical mucus	Dizziness
Dark circles around your eyes	Ringing in your ears
Low back pain before your period	Low libido
Feet cold, especially at night	Early morning loose stools
Cold menstrual cramps	Premature gray hair
Colder than those around you	

Spleen Function

Energy level: High Normal Low

Poor appetite	Feel heavy/sluggish	Energy lower after a meal
Heaviness in the head	Feel bloated after eating	Poor circulation
Crave sweets	Varicose veins	Bruise easily
Loose stools	Tired around ovulation	Spot before your period comes
Abdominal pain	Tired around menstruation	Nose cold
Indigestion	Nausea	Gas
Often sick	Hypoglycemia	

Stomach Function

Stomachache	Stomach ulcer	Acid reflux	Heartburn
Belching	Hiccups	Mouth ulcers	Bleeding Gums
Ravenous appetite	Bad breath	Nausea	Vomiting

Blood Function (liver, spleen, and heart system)

Menses scanty or late	Difficulty concentrating
Dry skin	Fainting
Chapped lips	Blurry vision
Weak or brittle nails	Poor night vision
Losing head hair	Hair dry/brittle

Heart Function

Heart palpitations	Forgetfulness	Hot hands
Anxiety	Depression	Hot feet
Mental restlessness	High blood pressure	Rapid heart beat
Chest pain	Heart murmur	Restless dreams
Hemophilia	Tongue ulcers	Insomnia
Manic moods	Speech impediment	Arrhythmia
Severe shyness	Low blood pressure	Wake up in the early am

Lung Function

Persistent cough	Chronic allergies	Dry or flaky skin
Nose bleeds	Nasal dryness	Sneezing
Difficulty breathing	Sinus congestion	Sore throats
Wheezing	Cigarette smoking	Allergies

If you are a smoker, how many cigarettes per day? _____
How long have you been smoking? _____
If you are a smoker, do you want to quit? YES NO
Level of determination to quit: 1 2 3 4 5 6 7 8 9 10

Bowl Function and Elimination

Loose stools	Constipation	Difficulty moving bowels
I.B.S or colitis	Diarrhea	Blood in stools
Small, hard, dry stools	Crohn's disease	Incomplete stools
Mucus in stools	Less than 1 BM/Day	Eating disorder

Accumulated Dampness

Mental fogginess	Swollen hands	Edema in the legs
Mental sluggishness	Swollen feet	Edema in the abdomen
Poor mental focus	Joint stiffness/ache	Chest congestion

Heaviness of the head, the limbs or of the whole body

Liver and Gallbladder Function

Chest pain	Irritability	Depression	Skin rashes
Chest tightness	Easy to anger	Pain in the ribcage	Acne
All over body tension	Easily frustrated	Headaches	Muscle spasms
Convulsions	Chronic neck tension	Migraines	Muscle cramps
Numbness/tingling	Shoulder tension	Gall stones	Lump in throat
Eye dryness	Seizures	Ringing in the ears	PMS
Breast tenderness	Nipple pain	Painful periods	

Wake with bitter taste in mouth
Difficulty falling asleep at night
Alternating diarrhea and constipation
Easily overwhelmed by stressful circumstances

Urinary Function

Normal color	Reddish color	Small amount	Dribbling
Dark yellow	Cloudy	Large amount	UTI
Clear color	Strong odor	Very frequent	Pain/burning urination
Frequency: _____ times at night		Urgency	
_____ during the day			

Libido Function

Normal	Diminished sex drive	Lack of desire
High sex drive	Sexual addiction	

Prescription Medications & Over the Counter Medications & Supplements

Prescription Medications:

Please list by name any prescription medications you are taking on a regular basis.
Enter as much of the requested information as you can. The first entry serves as an example.

Product Name	Dosage	Times per day	Prescribed by	Prescribed for
Diovan HCT	80/12.5 mg	1	Dr. Smith	High Blood Pressure

Over-the-Counter Medications and Supplements:

Please list by name any over-the-counter medications, vitamins or other supplements you are taking on a regular basis.

Brand Name	Product Name	Dosage	Times per day	Prescribed by	What it is for
Metagenics	Ultra Meal 360 Plus	52 g	2	Dr. Lee	Diabetes

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