Q1345SLO Family Acupuncture

2066 Chorro St ♦ San Luis Obispo, CA 93401
(805) 242-6852 ♦ www.slofamilyacupuncture.com

Name _____ Date _____ DOB _____

Please answer the following questions to the best of your knowledge:

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

Do you have a diagnosis of infertility? _____ When? _____ What? _____

Have you had fertility treatments in the past? _____ What types? _____

Have you had a fertility work up? ☐ Yes ☐ No

What was your sperm count? ☐ Below normal ☐ Normal Number_____

What was the sperm motility? ☐ Below normal ☐ Normal Specifics_____

Any issues with sperm morphology? ☐ Yes ☐ No Describe_____

How is your sexual energy? ☐ Low ☐ Normal ☐ High

Do you have undescended testes? ☐ Yes ☐ No

Have you ever been diagnosed with a varicocele? ☐ Yes ☐ No

Have you had any urologic surgeries? ☐ Yes ☐ No

Have you had a vasectomy reversed? ☐ Yes ☐ No

Have you experienced difficulty maintaining an erection? ☐ Yes ☐ No

Have you experienced difficulty ejaculating? ☐ Yes ☐ No

Do you regularly experience nocturnal emissions? ☐ Yes ☐ No

Have you experienced penile discharge? ☐ Yes ☐ No

Have you ever been diagnosed with a sexually transmitted disease? ☐ Yes ☐ No

If yes, what was the diagnosis, and when was it given?_____

Do you have any sores on your genitalia? ☐ Yes ☐ No

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

Do you smoke? ☐ Yes ☐ No

Do you eat soy products? ☐ Yes ☐ No

Do you eat a lot of processed foods? ☐ Yes ☐ No

Do you regularly consume caffeine? ☐ Yes ☐ No

If yes, what types of caffeine, how much, and how often?_____

Do you participate in recreational drugs? ☐ Yes ☐ No

If yes, what kind of drugs, and how often?_____

Thank you for taking the time to complete this intake form. I look forward to working with you.
–Carla Nerelli, L.Ac

Please list any prescription medications you are taking, dosage, and reason why:

_____

_____

_____

_____

Please list any non-prescription medications you are currently taking, including herbs, supplements, vitamins, and over-the-counter medications:

_____

_____

_____

Any other concerns or comments? _____

_____

_____

_____

For Clinic Office Use:

Thank you for taking the time to complete this intake form. I look forward to working with you.
–Carla Nerelli, L.Ac