SLO Family Acupuncture

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Name _____ Date _____ DOB _____

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

How long have you been trying to conceive? _____

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 ☐ N

Have you been given a diagnosis of infertility? _____ When? _____ What? _____

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

Have you had a fertility work up? ☐ Yes ☐ N When?_____

Results _____

Has your partner had a fertility work up? ☐ Yes ☐ No When?_____

Results _____

Have you had your hormone levels tested? ☐ Yes ☐ No When?_____

Results _____

Have your fallopian tubes been evaluated medically? ☐ Yes ☐ N Results? _____

Have you ever done a BBT chart? ☐ Yes ☐ No (Please bring copies of any recent charts)

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

What methods do you use to determine ovulation?_____

Have you taken oral contraceptives? ☐ Yes ☐ N Have you ever had an IUD? ☐ Yes ☐ N

If yes to either, when and for how long? _____ What kind? _____

Do you experience pain before, during, or after menses, or during ovulation? ☐ Yes ☐ No

Please indicate the quality of pain and when you experience the pain below

Cramping _____ Stabbing _____ Burning _____ Aching _____ Bloating _____

Dull _____ Consistent _____ Intermittent _____ Bearing down sensation _____

Do you experience any of the following symptoms related to your menses? Circle all that apply.

Nausea	Vaginal dryness	Decreased libido	Increased libido	Night sweats
Diarrhea	Constipation	Ravenous appetite	Poor appetite	Hot flashes
Headache	Mood swings	Swollen breasts	Acne	Low back pain

What color is the blood? ☐ Light Red ☐ Red ☐ Dark Red ☐ Purple ☐ Brown ☐ Black

How heavy is the bleeding? ☐ Light ☐ Normal ☐ Heavy

Any clots? ☐ Yes ☐ No At what point of menses? _____ Color? _____

Do you bleed or spot between periods? ☐ Yes ☐ No

Do you experience a change in cervical mucus at different times during your cycle? ☐ Yes ☐ No

Please indicate the types of cervical mucus you experience at different times of your cycle.

Dry _____ Creamy _____ Eggwhite _____ Sticky/Pasty _____ Watery _____Other _____

Do you have chronic vaginal discharge? ☐ Yes ☐ No Any odor?_____

Do you get yeast infections regularly? ☐ Yes ☐ No

Do you douche regularly? ☐ Yes ☐ No

Have you ever had a venereal disease? ☐ Yes ☐ No

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

Have you ever had pelvic inflammatory disease? ☐ Yes ☐ No When?_____

Have you been treated for it? ☐ Yes ☐ No How? _____

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

Have you had any tubal operations? ☐ Yes ☐ N

Have you ever been diagnosed with uterine fibroids? ☐ Yes ☐ No When? _____

If yes, were you ever told the size or position of the fibroids? _____

Have you ever been diagnosed with endometriosis? ☐ Yes ☐ No

If yes, please list any symptoms you experience _____

Have you ever been diagnosed with polycystic ovarian syndrome (PCOS)? ☐ Yes ☐ No

If yes, please list any symptoms you experience _____

Have you ever been diagnosed with pelvic adhesions? ☐ Yes ☐ No

Have you ever been diagnosed with premature ovarian failure? ☐ Yes ☐ No

Have you ever been diagnosed with early menopause? ☐ Yes ☐ No

Have or, are you currently going through menopause? ☐ Yes ☐ No

If yes, please list your symptoms _____

Have you ever taken medications for gynecological conditions? ☐ Yes ☐ No

If yes, please list the name, reason, and for how long you were taking medication below.

_____

_____

_____

_____

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

Do you experience pain during sexual intercourse? ☐ Yes ☐ No

Do you use vaginal lubricants? ☐ Yes ☐ No What kind? _____

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 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 any 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

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?_____

Do you exercise regularly? ☐ Yes ☐ N

What do you do for exercise? _____ How often? _____

Do you often feel stressed? ☐ Yes ☐ No

Which areas of life regularly cause you stress? Please circle all that apply

Work Finances Family Home Significant Other Health

Diet Weight Exercise Sex Other_____

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? _____

_____

_____

_____

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