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Natural Fertility Program

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PERSONAL INFORMATION

(Female intake form)

❑ Ms. ❑ Mrs. Name:

Address: Apt #

City: State: Zip:

Home Phone: Alternate Phone:

Email:

Date of Birth: / / Place of Birth:

Any known complications at birth:

Occupation:

Occupational Stress: ❑ chemical ❑ physical ❑ psychological ❑ Other:

How many hours/week do you work? Are you satisfied with your job?
❑ Yes ❑ No

Marital Status: ❑ single ❑ married ❑ divorced ❑ widowed ❑ mutually committed

Have you ever had acupuncture? ❑ Yes ❑ No, when?

For what condition?

Was it a good experience? ❑ Yes ❑ No

How were you referred to us?

Can we contact him/her to thank them for the referral? ❑ Yes ❑ No

MEDICAL HISTORY

What are your reasons/concerns for seeking treatment?

1.-

2.-

3.-

4.-

5.-

When did your health concerns begin?

Your condition is improved by

Your condition is aggravated by

Are you currently under the care of a physician? ❑ Yes ❑ No

For what condition(s)?

Physician's Name: Address:

City: State: Zip:

Phone: Date of last medical doctor visit: / /

What was the reason for your visit to your medical doctor?

Was there a diagnosis offered?

What other methods of therapy (conventional and alternative) have you used for this condition?

Therapy Therapist name Date / /

Response

Therapy Therapist name Date / /

Response

Therapy Therapist name Date / /

Response

Family Medical History (please check all that apply to PARENTS/SIBLINGS):

- ❑ Diabetes Who? _____
- ❑ Cancer Who? _____
- ❑ Heart Disease Who? _____
- ❑ Stroke Who? _____
- ❑ High Blood Pressure Who? _____
- ❑ Seizures Who? _____
- ❑ Asthma Who? _____
- ❑ Allergies Who? _____
- ❑ Other _____

Personal Significant illnesses (please check all that apply TO YOU):

- ❑ Allergies To: _____
- ❑ Cancer
- ❑ Diabetes: ❑Type I (insulin usage) ❑Type II
- ❑ Hepatitis: ❑ A ❑ B ❑ C
- ❑ Heart Disease
- ❑ Stroke
- ❑ Seizures
- ❑ HIV / AIDS
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Multiple sclerosis
- ❑ Thyroid
- ❑ Asthma
- ❑ Stomach Ulcers
- ❑ Obesity
- ❑ Depression
- ❑ Shingles
- ❑ Chronic Fatigue
- ❑ Rheumatic Fever
- ❑ High Blood Pressure
- ❑ STD's
- ❑ Other _____

Please list any **surgical procedures** you have had:

Surgery Date

Surgery Date

Surgery Date

Surgery Date

Please list **prescribed** medications you are currently taking and for what condition:

Medication_____Condition_____
Medication_____Condition_____
Medication_____Condition_____
Medication_____Condition_____
Medication_____Condition_____

Please list **over-the-counter** medications you are currently taking and for what condition:

Medication_____Condition_____
Medication_____Condition_____
Medication_____Condition_____
Medication_____Condition_____
Medication_____Condition_____

Please list any **vitamins, supplements, and herbs** you are taking:

Product_____Condition_____
Product_____Condition_____
Product_____Condition_____
Product_____Condition_____
Product_____Condition_____

Please mark in the following table how often do you experience the listed emotions:

Emotion	Never	Sometimes	Often	Always	
Happy					
Peaceful					
Anxious					
Relaxed					
Joy					
Anger					
Fear					
Worry					
Depression					
Sadness					

GYNECOLOGY HISTORY:

Height: cm. Weight: kg.

Have you ever had an abnormal Pap smear? If yes, when?

Date of last Pap smear?

Have you had any gynecological surgeries?

When? Type of surgery:

Have you ever taken hormonal birth control (pills, shot, ring, patch, ect…)
When? How long?

Have you ever used an IUD?
When? How long?

Have you ever had any of the following?

- ❑ Chronic yeast infections
- ❑ Chronic vaginal discharge
- ❑ Painful intercourse

	How Many?	Year
Pregnancies	_____	_____
Births	_____	_____
Miscarriages	_____	_____
Abortions	_____	_____
D&C's	_____	_____

Have you ever experienced any sexual abuse? ❑ Yes ❑ No

Have you ever been raped? ❑ Yes ❑ No

If yes to either of these questions, have you received counseling or treatment related to these traumas? ❑ Yes ❑ No

What type?

FERTILITY HISTORY:

How long have you been trying to conceive?

Do you have a diagnosis related to infertility?

Have you had your hormone levels tested? ❑ Yes ❑ No

FSH	_____
Estradiol (E2)	_____
LH	_____
Prolactin	_____
Progesterone	_____
Thyroid	_____
Testosterone	_____

Have you had your fallopian tubes evaluated? ❑ Yes ❑ No
Results

Have you had your uterus evaluated? ❑ Yes ❑ No
Results

Has your partner had his sperm evaluated? ❑ Yes ❑ No
Results

Have you had fertility treatments? ❑ Yes ❑ No

Please, explain what treatments and when:

MENSTRUAL CYCLE

Age of first menses:

Date of last menstrual cycle:

Do you have regular menstrual cycles? ❑ Yes ❑ No

How many days in between your cycles? How many days do you have bleeding?

Amount of bleeding? ❑ Light ❑ Medium ❑ Heavy

Do you experience pain? ❑ Low back ❑ Uterus

Which days?

What color is the blood? ❑ Pink ❑ Red ❑ Dark Red ❑ Purple ❑ Brown ❑ Black

Does the blood contain clots? ❑ Yes ❑ No

Does the blood contain mucous? ❑ Yes ❑ No

Is the blood liquid in consistency? ❑ Yes ❑ No

Do you ovulate? ❑ Yes ❑ No If yes, what day of the cycle?

Do you notice slippery, egg-white discharge leading up to ovulation? ❑ Yes ❑ No

PREMENSTRUAL SYMPTOMS

Check if you have the following:

- ❑ Sore/tender breasts
- ❑ Irritability/ depression
- ❑ Acne breakouts

Headaches (circle one)	❑ Before	❑ During	❑ After cycle
Low back pain (circle one)	❑ Before	❑ During	❑ After cycle
Loose bowl movements (circle one)	❑ Before	❑ During	❑ After cycle

MISCELLANEOUS

Do you tend to be warm or cold? ❑ Warm ❑ Cold
Do you have cold hands and feet? ❑ Yes ❑ No
Do you experience night sweats? ❑ Yes ❑ No How often?_____
Do you have hot feet at night? ❑ Yes ❑ No
How is your sexual energy? (circle one) ❑ Low ❑ Medium ❑ High
Has is your relationship with your husband? ❑ Poor ❑ Good ❑ Excellent
Do you have support from friends and family? ❑ Yes ❑ No
Do you use vaginal lubricants during sex? ❑ Yes ❑ No
Do you produce sufficient fluids during sex? ❑ Yes ❑ No
Do you have difficulty achieving orgasm? ❑ Yes ❑ No

Number of brothers and sisters:

Where are you in the birth order? ❑ Oldest ❑ Middle ❑ Youngest

How many years between you and closest siblings?

Did your mother have any miscarriages?

How old was your mother when you were born?

How was your mother's pregnancy with you? Were there any major stressful events?

Do you know the age that your mother began going through menopause?

DIET, EXERCISE & LIFESTYLE

Do you have a regular exercise program? ❑ Yes ❑ No. Please, describe:

How many meals do you have per day? How many snacks?

Are you or have you ever been on a restricted diet? ❑ Yes ❑ No. What kind?

What foods/flavors do you crave?

Please describe your average daily diet:

Morning	Afternoon	Evening

Dietary preferences:

___ Vegetarian
___ Vegan
___ Raw foods diet
___ Low fat diet
___ High protein/low carb
___ Dairy /milk /cheese
___ Eggs
___ Chicken
___ Fish / seafood
___ Red meat
___ Artificial sweeteners

___ Fast food/ burgers/ fries
___ Spicy / hot
___ Sweet
___ Sour
___ Salty
___ Cold drinks
___ Hot drinks
___Ice chewing
___Extreme thirst
___Thirst with no desire to drink

Do you take any of the following:

Coffee:	❑ Yes ❑ No	#____/week	❑ Regular ❑ Decaf
Alcohol:	❑ Yes ❑ No	#____/week	What? _____
Soda:	❑ Yes ❑ No	#____/week	❑ Diet ❑ Regular
Cigarettes:	❑ Yes ❑ No	#____/day	(Brand:_____)
Recreational Drugs:		#____/week	(Type:_____)

How is your sleep:

❑ I sleep well.
❑ It's hard to fall sleep
❑ It's hard to stay sleep
❑ I wake up every night at _____
❑ I wake up refreshed
❑ I wake up tired

How many hours/night do you sleep? _____ What time do you go to bed? _____

Do you have recurring dreams? ❑ Yes ❑ No. If yes, explain:

_____

_____

Do you use any of the following products?

- ❑ anti-perspirant
- ❑ hair dyes/permanents/relaxers
- ❑ cellular phone, #of mins per day_____
- ❑ computer, # hours per day_____
- ❑ commercial household cleaning products

Mark any of the following symptoms that applies to you in the last 6 months:

General symptoms
___ Fatigue
___ Sweat without exertion
___ Night sweats
___ Fever / chills
___ Dizziness / vertigo
___ Bleed / bruise easily
___ Low immunity
___ Other _____

Digestion
___ Extreme appetite
___ No appetite
___ Cravings
___ Dieting
___ Tired after eating
___ Bloating
___ Gas
___ Acid regurgitation
___ Heartburn/Ulcers
___ Nausea
___ Vomiting
___ Bulimia
___ Irritability or low energy between meals
___ Other _____

Intestinal
___ Daily Bowel movement
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Anal itching / burning
___ Laxative use
___ Bloody stool
___ Mucous in stool
___ Contain undigested food
___ Anal fissures
___ Intestinal pain/cramping
___ Incomplete evacuation
___ Hard to push out
___ IBS
___ Colitis
___ Gout
___ Gallstones
___ Other _____

Sleep
___ Fall asleep easily
___ Lie in bed with eyes open
___ Wake at specific times
___ Wake repeatedly
___ Wake frequently to urinate
___ Vivid or Lucid Dreams
___ Wake up not feeling rested
___ Nightmares or frightening dreams
___ Need drugs or supplements to fall asleep

Head, Eyes, Ears, Nose and Throat
___ Dry eyes
___ Spots / flowery vision
___ Blurred vision
___ Poor vision
___ Eye strain
___ Night blindness
___ Cataracts
___ Macular degeneration
___ Bleeding gums
___ TMJ
___ Sores on tongue or mouth
___ Dry mouth
___ Excess saliva
___ Sinus problems
___ Post-nasal drip
___ Sore throat
___ Headaches
___ Swollen glands
___ Difficulty swallowing
___ Earaches
___ Tinnitus / ringing
___ Deafness
___ Nosebleed
___ Other_____