



# Patient Intake Form

## Contact Information

12188-A North Meridian, Suite 225 | Carmel, IN 46032 | 317.846.8777 | Fax 317.846.8834 | www.IndianaReproductiveAcupuncture.com

NAME (FIRST, MIDDLE, LAST)	DATE
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AGE	DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED
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HOME ADDRESS
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CITY	STATE	ZIP
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CELL PHONE	HOME PHONE	WORK PHONE
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WHAT IS THE BEST DAY TIME PHONE NUMBER TO REACH YOU? <input type="checkbox"/> CELL PHONE <input type="checkbox"/> HOME PHONE <input type="checkbox"/> WORK PHONE	MAY WE CALL YOU AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO
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E-MAIL ADDRESS	IS E-MAIL A GOOD WAY TO CONTACT YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO
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EMPLOYER	OCCUPATION
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SPOUSE/PARTNER NAME
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EMERGENCY CONTACT	RELATIONSHIP	EMERGENCY CONTACT PHONE
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PRIMARY PHYSICIAN
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HOW DID YOU HEAR ABOUT US? (Doctor's name, Nurse, Doctor office staff, website, brochure, friend, etc)
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## Medical History

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MAJOR COMPLAINT/HEALTH PROBLEM

.....

.....

HOW DID THIS CONDITION DEVELOP?

.....

.....

HOW LONG HAS THIS CONDITION PERSISTED?

IS THERE ANYTHING THAT MAKES IT BETTER?

IS THERE ANYTHING THAT MAKES IT WORSE?

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHEN?
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WHERE?	BY WHOM?
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WHAT WAS THE DIAGNOSIS?	WHAT KIND(S) OF TREATMENT?
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WHAT WERE THE RESULTS OF THE TREATMENT?

LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO:

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING: MEDICATION	STRENGTH	HOW MANY PER DAY	FOR HOW LONG
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST ANY MAJOR SURGERIES YOU HAVE HAD:	
DATE	PROBLEM/SURGERY
_____	_____
_____	_____
_____	_____

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC)

.....

.....

SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Connective Tissue Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> AIDS	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ruptured Appendix	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	

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Please check any symptoms you currently have or have had in the past year.

**General**

- Chills
- Low energy
- Dizziness
- Allergies
- Fatigue
- Fevers
- Excess thirst
- Insomnia
- Nervousness
- Numbness
- Sweat spontaneously
- Night sweating
- Lack of sweating
- Weight loss
- Weight gain
- Aversion to heat
- Aversion to cold

**Head & Neck**

- Blurred vision
- Heaviness in the head
- Headache
- Phlegm in throat
- Cataract
- Double vision
- Earache
- Ear discharge
- Eye pain/strain
- Corrected vision
- Nasal obstruction
- Nasal discharge
- Loss of sense of smell
- Hearing loss
- Hoarseness
- Nosebleeds
- Recurrent sore throat
- Red/inflamed eye
- Ringing in ears
- Sinus problems
- Sores on lips
- Sores on tongue
- Taste change
- Teeth problems
- Vision - see halos

**Respiratory**

- Asthma
- Hay fever
- Persistent cough
- Coughing blood
- Shortness of breath
- Recurrent bronchitis
- Phlegm production
- Difficulty inhaling
- Difficulty exhaling

**Cardiovascular**

- Chest pain
- High blood pressure
- Low blood pressure
- Irregular heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins
- Hypochondriac pain
- Distention in chest or hypochondrium

**Gastrointestinal**

- Abdominal pain
- Bloating
- Belching
- Gas
- Constipation
- Diarrhea/loose stools
- Bloody stools
- Difficulty swallowing
- Poor appetite
- Heartburn/reflux
- Hemorrhoids
- Indigestion
- Stomachache
- Nausea
- Vomiting
- Vomiting blood

**Diet/Lifestyle**

- Vegetarian
- Healthy diet
- Eat much fried foods
- Eat much meat
- Smoke cigarettes
- Drink alcohol
- Drink Coffee
- Use drugs
- Eat a lot of sweets
- Take melatonin
- Take steroids
- Exercise regularly
- Exercise excessively

**Weight**

- Underweight
- Normal for height
- Overweight
- Very overweight

**Genitourinary**

- Dilute urine
- Dark urine
- Blood in urine
- Cloudy urine
- Burning urination
- Scanty urine
- Profuse urine
- Frequent urination
- Poor bladder control
- Urgency to urinate

**Musculoskeletal**

Pain, weakness, numbness in:

- Arms
- Feet
- Hands
- Joints
- Legs
- Hips
- Neck
- Shoulders
- Pain all over
- Cold limbs
- Knee problems
- Low back pain
- All over weakness
- Lack of strength
- Broken bones

**Skin**

- Thick skin
- Thin skin
- Broken blood vessels
- Blood not clotting
- Bruise easily
- Discoloration
- Dark circles around eyes
- Bags under eyes
- Lumps in groin
- Lumps underarm
- Dry skin
- Acne
- Brittle nails
- Premature gray hair
- Dry, brittle hair
- Hair falling out

**Neurologic**

- Fainting
- Convulsions
- Handwriting change
- Paralysis
- Stroke
- Seizures
- Tremor
- Recent clumsiness
- Drowsiness
- Vertigo

**Emotional**

- Insomnia
- Irritability
- Often feel angry
- Troubling dreams
- Cry uncontrollably
- Feel sad a lot
- Forgetful
- Mind not clear
- Anxiety
- Much fear
- Unrestrained joy
- Terrors
- Difficulty expressing emotions

**Men Only**

- Genital pain
- Impotence
- Genital sores
- Lump in testicles
- Penis discharge
- Nocturnal emission
- Low sexual energy

**Women Only**

- Abnormal pap smear
- Bleed between periods
- Irregular periods
- Heavy Periods
- <25 day cycle
- >35 day cycle
- Endometriosis
- Painful periods
- Premenstrual tension
- Breast lumps
- Contraceptives
- Sores on genitalia
- Low sexual energy
- Vaginal discharges
- Menopausal
- Uterine prolapse
- Facial hair
- Loss of head hair
- May be pregnant



# Patient Intake Form

## Men's Fertility History

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

How would you define your sexual energy? .....  Below normal       Normal

Do you have an undescended testes? .....  Yes       No

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

Have you had any urologic surgeries? .....  Yes       No

Have you experienced difficulty maintaining erection? .....  Yes       No

Have you experience difficulty ejaculating? .....  Yes       No

Have you had exposure to any known environmental toxins or hormones? .....  Yes       No

Have you experienced any penile discharge? .....  Yes       No

Do you regularly experience nocturnal emission? .....  Yes       No

Have you had a fertility workup? .....  Yes       No

If yes, what was your sperm count?       Below normal       Normal      Number \_\_\_\_\_

What was the sperm motility?       Below normal       Normal      Notes \_\_\_\_\_

What was the sperm morphology?       Abnormal       Normal      Notes \_\_\_\_\_

COMMENTS/NOTES