Dr. Hillary, ND

www.mardaloopwellness.com

ACUPUNCTURE INTAKE FORM- FERTILITY

Thank you for taking the time to complete the following new patient forms. Given this form is extensive, it plays an integral role in achieving our mutual goal of your optimal health.

Name			Date
Birth Date d d / m m / y y y y	Age	Gender	Home #
Address			
City	Province		Postal Code
Phone number (preferred number used):		May we leave messages?	
Email Address:			
Occupation:			
Emergency Contact (Name and Relationship and Phone Number):			
Family Doctor – Name and Contact		Date of last physical:	
		Date of last blood work:	
How did you hear about Dr. Hillary?			

Please provide the reason you are seeking acupuncture treatment:

____

____

____

Have you tried other conventional or alternative treatments? If so, what were they and what were the results?

____

____

____

Please list any medications and/or supplements you are currently taking (Include vitamins, herbs, natural products and pharmaceuticals as well as dosage and frequency:

___

___

___

Which of the following illnesses and conditions have you had (past and present)? Please check all that apply:

SKIN HAIR AND NAILS

- ______ Acne
- ______ Psoriasis
- ______ Warts (genital of facial)
- ______ Eczema
- ______ Roseola
- ______ Chicken Pox

HEAD, EARS, EYES, NOSE, THROAT

- ______ Migraines
- ______ Headaches
- ______ Mononucleosis
- ______ Frequent Colds
- ______ Ear Infections
- ______ Eye Infections
- ______ Strep Throat
- ______ Hay Fever
- ______ Sinusitis
- ______ Tonsillitis
- ______ Mumps
- ______ Malaria

PELVIC ISSUES

- ______ Sexually Transmitted Infections
- ______ Candida (Yeast)
- ______ Infertility

ENDOCRINE

- ______ Diabetes
- ______ Hypothyroidism
- ______ Hyperthyroidism

MENTAL, EMOTIONAL, GENERAL

- ______ Depression
- ______ Anxiety
- ______ Chronic Fatigue
- ______ Multiple Sclerosis
- ______ Schizophrenia
- ______ Eating Disorder
- ______ Lupus
- ______ HIV
- ______ Bipolar Disorder
- ______ Epilepsy
- ______ Hyperactivity
- ______ Joint Pain
- ______ Arthritis/Rheumatoid/Osteo

CARDIOVASCULAR AND RESPIRATION

- ______ Difficulty Breathing
- ______ Heart Disease
- ______ Whooping Cough
- ______ Tuberculosis
- ______ High Blood Pressure
- ______ Heart Palpitations
- ______ Heart Murmur
- ______ Frequent Coughs
- ______ Shortness of Breath
- ______ Pneumonia
- ______ Croup
- ______ Stroke
- ______ Rheumatic Fever

GASTROINTESTINAL

- ______ Bloating
- ______ Gas
- ______ Liver Disease
- ______ Stomach or intestinal Ulcers
- ______ Prostatitis
- ______ Hepatitis
- ______ Gall Stones
- ______ Pancreatitis
- ______ Diverticulitis
- ______ Kidney Disease
- ______ Kidney Stones
- ______ Irritable Bowel Syndrome
- ______ Constipation
- ______ Chrons' Disease
- ______ Acid Reflux
- ______ Hernia
- ______ Hemorrhoids

OTHER

- ______ Seizures/epilepsy
- ______ Insomnia/sleep issues
- ______ Anemia
- ______ High/low blood pressure
- ______ liver/gall bladder disease
- ______ Chronic pain issues
- ______ Cholesterol issues

Women's Health

Age of first menstrual period: _____ Duration of period? _____ Length of cycle? _____

When was your last menstrual period? _____ Are your cycles regular? _____ Painful menses? _____

How heavy is your bleeding? LIGHT NORMAL HEAVY

What color is your blood? LIGHT RED RED DARK RED PURPLE BROWN BLACK

Is there clotting? If yes, they are: BIG CLOTS SMALL CLOTS

Do you bleed or spot in between periods? YES NO

Are you pregnant? YES NO If yes, how many weeks? _____ Whose care are you under? _____

Birth control Method: ____

Birth control Method in the past (include how long used): ________________________________

Endometriosis? YES NO Cervical dysplasia? YES NO Ovarian cysts/fibroids? YES NO

Abnormal pap smear? YES NO How many children do you have? _____

How many pregnancies? _____ How many abortions? _____ How many miscarriages? _____

Do you get yeast infections regularly? YES NO

Have you ever had a venereal disease? YES NO

Have you ever had pelvic inflammatory disease? YES NO

Have you ever been diagnosed with any pelvic abnormalities? YES NO

Do you get premenstrual back pain? YES NO

Do your bowel movements become loose at the beginning of your period? YES NO

Please circle all that apply to you, in relation to your menstruation:

Heavy flow	Light flow	Clotting	Vaginal discharge
Vaginal dryness	Vaginal Itching	Vaginal Odor	Pain During intercourse
Abnormal Pap Test	Spotting between Periods	Breast Tenderness	Painful periods
Cramping	Cravings	Headaches	Bloating
Water retention	Irritability	Fatigue	Insomnia
Anxiety	Others: ____________		

Have you had a hysterectomy? YES NO

Fertility Questionnaire

Women

Please circle the following that apply or that you have consulted with other practitioners about:

NO OVULATION	FALLOPIAN TUBE BLOCKAGE
IRREGULAR PERIODS	THIN ENDOMETRIUM
POOR QUALITY OF EGGS	POOR QUANTITY OF FOLLICLES
LOW ESTRADIOL/PROGESTERONE	HIGH FSH
SHORT LUTEAL PHASE	UTERINE FIBROIDS
OVARIAN CYSTS	ENDOMETRIOSIS
ECTOPIC PREGNANCY	REPRODUCTIVE INFECTIONS

IVF/IUI

Approximate date of retrieval: _______________

Approximate date of transfer: _______________

Medications taken and start date of each: ____

____

Men

Please circle the following that apply or that you have consulted with other practitioners about:

SEXUAL ISSUES	MINIMAL/PREMATURE/NO EJACULATE
AUTOIMMUNITY	BLOCKAGE IN DUCT
VASECTOMY	HORMONE ISSUES
LOW SPERM VOLUME, COUNT, QUALITY	SEXUAL TRANSMITTED INFECTION
INJURY TO SCROTUM/TESTICLES	ABNORMAL MOTILITY

What is the consistency of your ejaculate? WATERY THICK BLOODY SCARCE NORMAL

Have you experienced spontaneous ejaculation? YES NO

Have you experienced premature ejaculation? YES NO

Do you ejaculate when you are sleeping? YES NO

Do you have concerns about erectile dysfunction? YES NO

Do you experience penile pain? Pain on urinating? YES NO

General TCM Health History

Please circle all that apply to you:

During the day do you feel:	CHILLS FEVERED PERSPIRATION WHEN NOT ACTIVE
Do you prefer to drink:	WARM/HOT FLUIDS COLD FLUIDS
Are you frequently thirsty:	YES NO SOMETIMES
Appetite:	POOR NORMAL GOOD VORACIOUS
After eating do you experience:	BLOATING GAS ACID REFLUX CRAVINGS FOR SWEET/SALT
Bowel movements:	CONSTIPATED DIARRHEA BOTH UNUSUAL ODOR MUCUS
	RUNNY DRY URGENCY TO GO FIRST THING IN THE MORNING
	UNDIGESTED FOOD IN STOOL BLOOD IN STOOL
Urine:	WAKE DURING THE NIGHT TO URINATE UNUSUAL COLOR
	UNUSUAL ODOUR MUCUS IN URINE BURNING SENSATION
	HIGH FREQUENCY URGENCY
Energy:	OFTEN TIRED NORMAL ENERGY LEVELS BETTER THAN NORMAL
	PHYSICAL WEAKNESS/FATIGUE MENTAL FATIGUE
	EASILY STARTLED
Pain:	LOWER BACK/MID BACK/UPPER BACK KNEES
	SHOULDERS HANDS LEGS FEET HEELS WHEN YOU
	WALK ARMS TENSION IN YOUR SHOULDERS/NECK
	OTHER
	** Please indicate if the pain is sharp, dull, achy, hot, cold, stabbing, shooting and moving
Headaches:	YES NO Where in your head?
Respiratory:	SHORTNESS OF BREATH FREQUENT COUGH OFFENSIVE BREATH
Hair/Teeth/Eyes:	HAIR or TEETH LOSS PREMATURE GREYING
	CLENCH OR GRIND TEETH DRY EYES BLURRY VISION
	FLOATERS STRAINED WHEN TIRED
Sleep:	DIFFICULTY FALLING ASLEEP DREAMS
	DIFFICULTY STAYING ASLEEP – If so what time do you wake?
	WAKING FEELING HOT/SWEATY FEEL ANXIOUS

HEART PALPITATIONS

What is your 'go to' emotion in a stressful situation? ANGER FEAR SADNESS WORRY SHOCK

Thank you for taking the time to fill this out – I look forward to meeting with you and working with you to provide your mind and body with optimal health!