



Renewed Health Acupuncture and Herbal Medicine
893 N. IH-35, Suite 140
Round Rock, TX 78664
(512) 341-9900

Fertility Patient Intake

Thank you for choosing Renewed Health as your wellness provider. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have any questions, please ask. Thank you. **Date** ___/___/___

Patient Name: (first) _____ (last) _____ (middle init.) _____

(preferred to be called) _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Male Female

Date of Birth: _____

Marital Status: S M D W

Emergency Contact

Name: _____

Phone: _____

Relationship: _____

Phone: (home) _____

(work) _____

(cell) _____

E-mail: _____

Family Physician: _____

Do you have health insurance? Yes No If yes, does your insurance cover Acupuncture? Yes No

How did you find out about us? _____

Current Health:

Hepatitis: Y N If Yes, type: (A/B/C/D) HIV/AIDS: Y N

Pacemaker? Y N Chronic infectious diseases? Y N Height: _____ Weight: _____

Significant Illness (please include month/year when the diagnosis was established)

Cancer _____ Thyroid disease _____ Diabetes _____ Seizures _____

Arthritis _____ Tuberculosis _____ Anemia _____ Sexually transmitted diseases _____

Fibromialgia _____ Heart disease _____ Emotional imbalance _____ Breathing problems _____

Surgeries/Hospitalizations/Traumas: _____

Allergies (drugs, chemicals, food): _____

Lifestyle:

Typical daily food intake: Very healthy Healthy ½ Healthy/ ½ not Healthy Not Healthy

Education: _____

Occupation: _____ How many hours do you work per week? _____

Do you enjoy your work? Y N Why/why not? _____

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Sandra Schwartz, L. Ac. (#AC01090), MAOM, Dipl. O.M. (NCCAOM)

| | | |
|---|-----|----|
| Do you have profuse vaginal discharge? | Yes | No |
| Does your menstrual blood tend to be dull in color? | Yes | No |
| Do you feel cold cramps during your period that respond to a heating pad? | Yes | No |
| Are you often fatigued? | Yes | No |
| Do you have a poor appetite? | Yes | No |
| Is your energy lower after a meal? | Yes | No |
| Do you feel bloated after eating? | Yes | No |
| Do you crave sweets? | Yes | No |
| Do you have loose stools, abdominal pain, or digestive problems? | Yes | No |
| Are your hands and feet cold? | Yes | No |
| Is your nose cold? | Yes | No |
| Are you prone to feeling heavy or sluggish? | Yes | No |
| Are you prone to feeling heaviness or grogginess in the head? | Yes | No |
| Do you bruise easily? | Yes | No |
| Do you think you have poor circulation? | Yes | No |
| Do you have varicose veins? | Yes | No |
| Are you lacking strength in your arms and legs? | Yes | No |
| Are you lacking in exercise? | Yes | No |
| Are you prone to worry? | Yes | No |
| Have you been diagnosed with low blood pressure? | Yes | No |
| Do you sweat a lot without exerting yourself? | Yes | No |
| Do you feel dizzy or light-headed, or have visual changes when you stand up fast? | Yes | No |
| Is your menstruation thin, watery, profuse, or pinkish in color? | Yes | No |
| Are you more tired around ovulation or menstruation? | Yes | No |
| Do you ever spot a few days or more before your period comes? | Yes | No |
| Have you ever been diagnosed with uterine prolapse? | Yes | No |
| Are your menstrual cramps accompanied by a bearing down sensation in your uterus? | Yes | No |
| Are you often sick, or do you have allergies? | Yes | No |
| Have you been diagnosed with hypothyroid or anemia? | Yes | No |
| Do you have hemorrhoids or polyps? | Yes | No |
| Are your menses scanty and/or late? | Yes | No |
| Do you have dry, flaky skin? | Yes | No |
| Are you prone to getting chapped lips? | Yes | No |
| Are your fingernails or toenails brittle? | Yes | No |
| Are you losing hair on your head (not in patches, but all over)? | Yes | No |
| Is your hair brittle or dry? | Yes | No |
| Do you have diminished nighttime vision? | Yes | No |
| Do you get dizzy or light-headed around your period? | Yes | No |
| Is your menstrual flow ever brown or black in color? | Yes | No |
| Do you feel mid-cycle pain around your ovaries? | Yes | No |
| Do you have painful, unmovable breast lumps? | Yes | No |
| Do you experience periodic numbness of your hands and feet (especially at night)? | Yes | No |
| Do you have varicose or spider veins? | Yes | No |
| Do you have red hemangiomas (cherry-red spots) on you skin? | Yes | No |
| Do you have chronic hemorrhoids? | Yes | No |
| Does your menstrual blood contain clots? | Yes | No |
| Have you been diagnosed with endometriosis or uterine fibroids? | Yes | No |
| Is your lower abdomen tender to palpation (resisting touch)? | Yes | No |
| Can you feel any abnormal lumps in your lower abdomen? | Yes | No |
| Do you have piercing or stabbing menstrual cramps? | Yes | No |
| Have you been diagnosed with any vascular abnormality or blood clotting disorder? | Yes | No |
| Are you prone to emotional depression? | Yes | No |
| Are you prone to anger and/or rage? | Yes | No |

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| | | |
|--|-----|----|
| Do you become irritable premenstrually? | Yes | No |
| Do you feel bloated or irritable around ovulation? | Yes | No |
| Does it feel as if your ovulation lasts longer than it should? | Yes | No |
| Are your breasts sensitive/sore at ovulation? | Yes | No |
| Do you experience nipple pain or discharge from your nipple? | Yes | No |
| Do you have a lot of premenstrual breast distention or pain? | Yes | No |
| Have you been diagnosed with elevated prolactin levels? | Yes | No |
| Do you become bloated premenstrually? | Yes | No |
| Do you have difficulty falling asleep at night? | Yes | No |
| Do you experience heartburn or wake up with a bitter taste in your mouth? | Yes | No |
| Are your menses painful? | Yes | No |
| Do you feel your menstrual cramps in the external genital area? | Yes | No |
| Is the menstrual blood thick and dark, or purplish in color? | Yes | No |
| | | |
| Do you wake up early in the morning and have trouble getting back to sleep? | Yes | No |
| Do you have heart palpitations, especially when anxious? | Yes | No |
| Do you have nightmares? | Yes | No |
| Do you seem low in spirit or lacking in vitality? | Yes | No |
| Are you prone to agitation or extreme restlessness? | Yes | No |
| Do you fidget? | Yes | No |
| Do you sweat excessively, especially on your chest? | Yes | No |
| | | |
| Are your mouth and throat usually dry? | Yes | No |
| Are you thirsty for cold drinks most of the time? | Yes | No |
| Do you often feel warmer than those around you? | Yes | No |
| Do you wake up sweating or have hot flashes? | Yes | No |
| Do you break out with red acne (especially premenstrually)? | Yes | No |
| Do you have a short menstrual cycle? | Yes | No |
| Do you have vaginal irritation or rashes? | Yes | No |
| | | |
| Do you feel tired and sluggish after a meal? | Yes | No |
| Do you have fibrocystic breasts? | Yes | No |
| Do you have urgent or foul-smelling stools? | Yes | No |
| Does your menstrual blood contain stringy tissue or mucus? | Yes | No |
| Are you prone to yeast infections, frequent vaginal infections, or vaginal itching? | Yes | No |
| Do your joints ache, especially with movement? | Yes | No |
| | | |
| Do you have foul-smelling, yellow or greenish vaginal discharge? | Yes | No |
| Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase? | Yes | No |
| | | |
| Does your lower abdomen feel colder to the touch than the rest of your trunk? | Yes | No |
| Do your breasts get tender at other times besides ovulation? | Yes | No |
| Do your bowel movements become loose or soft at the beginning of your period? | Yes | No |

I understand that the above information is complete and is correct to the best of my knowledge.

Signature: _____

Physician Evaluation

Pursuant to the requirements of Section 6.11, Subsection (d) V. A. C. S., article 4495b, governing the practice of Acupuncture

I (patient's name) _____, am notifying the licensed acupuncturist of **one** of the following:

1) I have been evaluated by a physician or dentist for the condition(s) being treated within the 6 months before this acupuncture treatment was performed. Yes ____ No ____

I recognize that I should be evaluated by a physician for the current condition(s) or any future condition(s) treated by the licensed acupuncturist _____ (patient initials)

2) I understand that the following conditions do not require evaluation from a physician within the last 6 months (please circle those that apply): Smoking Cessation Weight Loss Chronic Pain Cosmetic Facial Ac.

3) I have received a referral from my chiropractor within the last 30 days for acupuncture. Yes____ No____
After being referred by a chiropractor, after 30 days or 20 treatments, whichever comes first, if no substantial improvement occurs in the condition being treated, I understand that the licensed acupuncturist is required to refer me to a physician. It is my responsibility and **choice** whether to follow this advice.

Signature of Patient _____ Date: _____

Financial Policy

Most conditions require an average of 6-12 treatments, although some will respond well within 4-6 visits and others may require a longer series – this depends on the severity and the chronic nature of the chief complaint and how your body individually responds to the treatment.

Renewed Health is a Blue Cross Blue Shield provider and does accept insurance. Your insurance will be verified for in-network or out-of-network benefits. I understand that insurance verification is strictly an estimate and not a guarantee of payment according to my insurance company. I understand that this office will bill my insurance company as a courtesy to me, and if for any reason the insurance company does not pay or cover the services, that I will be directly responsible for payment to Renewed Health.

MasterCard, Visa, and Discover are accepted as well as cash and checks. Any checks with insufficient funds will be charged an additional \$30 by this clinic.

Your appointment time is reserved specifically for you. Cancellation of any appointment should be made within 24 hours prior to your scheduled time. We reserve the right to charge \$30 for cancellations less than 24 hours or for missed appointments.

Please indicate your understanding and acceptance of these policies by signing below.

Signature

Printed Name

Date