



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

NAME	DATE
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AGE	DATE OF BIRTH
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HOME ADDRESS		
CITY	STATE	ZIP

CELL PHONE	HOME PHONE	WORK PHONE
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

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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REPRODUCTIVE ENDOCRINOLOGIST
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HOW DID YOU HEAR ABOUT US? (Doctor's name, Nurse, Doctor office staff, website, brochure, friend, etc)	DO WE HAVE PERMISSION TO SEND THANK-YOU TO REFERRAL SOURCE? <input type="checkbox"/> YES <input type="checkbox"/> NO
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<p><b>CONSENT FOR ACUPUNCTURE</b></p> <p>I, _____, understand that I will be receiving a treatment from a licensed acupuncturist. I understand that treatment involves any or all of the following health care practices: Massage, Acupuncture.</p> <p>Acupuncture is the insertion of one or more thin needle(s) into the surface of the body. A patient may feel a slight pricking sensation near the needle. Patients usually report little or no pain during an acupuncture treatment. On occasion, there may be slight bruising or bleeding where a needle was inserted.</p> <p>The duration of a treatment is usually 30 minutes to 1 hour. Although no outcome of treatment is guaranteed, it is understood that every patient is unique and that each treatment is designed specifically for the condition of the patient. I understand that I have the right to consent to, or refuse treatment.</p> <p>Quality patient care is our primary concern. The optimal timing of your treatment is an important aspect of that care. If it is necessary to reschedule your appointment, we ask to be given 24 hours notice. We understand that sometimes scheduling conflicts arise that are unavoidable but we ask that you give us a 24 hour notice to avoid a \$50 cancellation fee.</p> <p>Signed: _____ Date: _____</p>
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NAME \_\_\_\_\_

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"/> Other: _____
<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	

LIST ANY MEDICATIONS AND/OR SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING:

MEDICATION	DOSAGE	DATE STARTED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ANY MAJOR SURGERIES YOU HAVE HAD RELATED TO FERTILITY:

DATE	SURGERY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



NAME \_\_\_\_\_

### Fertility History

WHEN DID YOU START TRYING TO CONCEIVE? \_\_\_\_\_

ARE YOU CURRENTLY IN THE MIDDLE OF, OR PREPARING TO START ANY FERTILITY TREATMENTS?

YES TREATMENT: \_\_\_\_\_ DOCTOR: \_\_\_\_\_

NO

HAVE YOU BEEN GIVEN A DIAGNOSIS RELATED TO FERTILITY?

YES DIAGNOSIS: \_\_\_\_\_ DOCTOR: \_\_\_\_\_

NO

PLEASE LIST ANY FERTILITY TREATMENTS THAT YOU HAVE ALREADY UNDERGONE:

DATE	DOCTOR	TREATMENT
01/2012	Dr. Green	IVF
07/2011	Dr. Blue	Clomid with timed intercourse
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HAVE YOU EVER HAD A SPERM ANALYSIS?

YES DATE: \_\_\_\_\_ RESULTS: \_\_\_\_\_

NO