NYGREN CHIROPRACTIC & ACUPUNCTURE

Fertility New Patient Form

Personal Information:

Name_____ DOB: _____ Age: _____
Address_____City_____State_____Zip_____
Phone _____ Email: _____
Occupation:_____Work Duties:_____
Exercise routine:_____
Other recreational activities/hobbies?_____
Marital Status: S M D W Name of Spouse_____Number of children_____
Emergency Contact: Name_____Relationship_____Phone _____
Health Care Providers: Medical Doctor: _____ Last seen:_____
Previous Chiropractor: _____ Last seen:_____
Massage Therapist: _____ Last seen:_____
Acupuncturist/Other:_____ Last seen: _____
Ob/Gyn:_____ Last seen: _____
Fertility Specialist:_____ Last seen: _____

Menses Information:

What day of your menstrual cycle are you currently on? _____
Average Cycle duration? _____ Pads/Tampons/Other:_____
Average days of flow? _____ Describe flow: _____
Been on birth Control before? Y N How long? _____ Type? _____
Giardisil vaccine? Y N

PMS symptoms? Y N List: _____
When do you have PMS during your cycle? _____
(1=least/low, 10= high/most) Rate your stress 1-10: _____ Rate your fatigue 1-10: _____
Excessive body or facial hair: Y N Rate your sex drive 1-10: ____ Frequent yeast infections? Y N
History of any sexually transmitted diseases? Y N List: _____

Fertility Tracking:

Do you take your basal temperature? Y N App Tracking? Y N
Cervical mucus checking? Y N Cervix position checking? Y N Ovulation Kits? Y N
Notes: _____
How long have you been trying to conceive? _____
Any miscarriages? _____
Treatments you've already tried or are currently trying: _____
_____
Have you had any tests run on your uterus, fallopian tubes or ovaries? Y N List: _____
_____

Partner Information:

Please list any tests your partner has had run: _____
Results: _____
General health status of your partner: _____

Nutritional Habits:

Typical Breakfast: _____
Typical Lunch: _____
Typical Dinner: _____
Supplements to help fertility: _____
Cravings: _____
Caffeine: _____
Household/environmental toxin exposure: (cleaning products, candles, scents, detergents, etc.): ____
_____

Case History:
Past accidents, falls, or injuries: _____
_____
Surgeries and hospitalizations with dates:_____
_____
Current prescription medications, vitamins & herbs and what they are for: _____
_____
_____

Family history of the same condition you have? Y N Family history of cancer, diabetes or heart illness? Y N Please list: _____

☑ Other health issues:

	Symptom:
	Acid Reflux
	Allergies
	Asthma/COPD
	Bladder Problems
	Cancer
	Depression
	Diabetes
	Diarrhea/Constipation
	Dizziness/Vertigo
	Epilepsy
	Fatigue/Fibro
	Gallbladder

	Symptom:
	Gout
	Headaches
	Heart Condition
	Hepatitis
	High Blood Pressure
	High Cholesterol
	HIV
	Insomnia
	Joint Pains
	Kidney Problems
	Menopause Symptoms
	Night Sweats

	Symptom:
	Pacemaker
	Skin Conditions
	Sleep Apnea
	Stomach Problems
	Stress!
	Stroke
	Thyroid Problems
	Tremors
	Vaccine Reaction
	Varicose Veins (Severe)
	Weight gain (unexplained)
	Other:

	Eating Habits:
	Caffeine—amount:
	Frequent Sugar (candy, cookies, donuts)
	Frequent Processed Foods (chips, boxed meals, etc)
	Artificial Sweeteners
	Soda—amount
	Energy Drinks—amount
	Frequent Fast Food
	4-8 Veggies/day
	1-3 Fruits/day
	6-8 glasses of water/day
	Special diet:

Patient Signature: _____ Date: _____