

MIND / BODY PROGRAM FOR INFERTILITY  
PROGRAM INTAKE ASSESSMENT

Name\_\_\_\_\_Date\_\_\_\_\_

Date of Birth\_\_\_\_\_Age\_\_\_\_\_

Street  
Address\_\_\_\_\_City\_\_\_\_\_Zip\_\_\_\_\_

Partner's  
Name\_\_\_\_\_

Phone Numbers: Home/Eve ( ) \_\_\_\_\_  
Work/Day( ) \_\_\_\_\_

E-mail\_\_\_\_\_

How did you hear about this  
program?\_\_\_\_\_

Referring  
Physician\_\_\_\_\_

OB/GYN or Reproductive Specialist  
(if different from above)\_\_\_\_\_

Marital Status: (check one)  
Married \_\_\_\_\_Single\_\_\_\_\_Divorced\_\_\_\_\_

Separated\_\_\_\_\_ Widowed\_\_\_\_\_

Living in Committed Relationship\_\_\_\_\_

If married, how long? \_\_\_\_years

Occupation:\_\_\_\_\_

Are you currently working? \_\_\_\_\_Part time \_\_\_\_\_Full time

Education level: (check highest level achieved)

\_\_\_\_\_Grade School \_\_\_\_\_High school  
\_\_\_\_\_ College \_\_\_\_\_Graduate school

Please rate your overall, general health: (please circle a number)

0 1 2 3 4 5 6 7 8 9 10  
unhealthy/ill very healthy

Previous history of:

Anxiety?\_\_\_\_\_

Depression?\_\_\_\_\_

Are you pursuing any alternative treatments for your infertility? (These might include acupuncture, Chinese medicine, herbs, chiropractic, energy work, massage, homeopathy). Please describe:

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List any prescribed medicines you are taking, including dosage (not related to infertility treatments):

Length of time trying to conceive:\_\_\_\_\_

Brief history of infertility:\_\_\_\_\_

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List any infertility treatments or procedures you are currently undertaking:

Is your infertility:

Primary? (no previous pregnancies to term)\_\_\_\_\_

Or secondary? (Previous children, but cannot conceive currently)\_\_\_\_\_

If secondary infertility, list names and ages of children: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any previous miscarriages? \_\_\_\_\_ How many? \_\_\_\_\_

Are you currently in psychotherapy? \_\_\_\_\_

Are you currently under the care of a psychiatrist? \_\_\_\_\_

If so, name of psychiatrist: \_\_\_\_\_

What is your motivation for enrolling in the Mind/Body Program for Infertility:

What goals do you hope to achieve during this program?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please complete and mail to:

Mind/Body Program  
238 E. Davis Blvd. Suite 313  
Tampa, FL 33606