Intake Form: Men Heavenly Star Acupuncture

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| --- | --- |
| Name:  | Date of birth:  |
| Relationship status:  | Children:  |  |
| Address:  |  |
| Phone: |  |
| Email: |  |
| **Chief complaint (describe it in detail)** |  |
| Since when? |
| Any treatment/therapy or medicine?Any progress?Anything which relieves or worsens the situation?  |
| Has it happened before? |
| Is it family related?  |
| **Past history of diseases and medicine use (e.g. heart disease, diabetes, hypertension etc.)**  |  |
| Any operations? |  |
| Any major scars? |  |
| Any family diseases? |  |
| Results of examinations by western medicine doctors?  |  |
| **General information**  |
| How well do you sleep (dreams/nightmares), duration of sleep etc.? |  |
| Diet /appetiteAny restrictions?Food allergies? |  |
| Digestion? |  |
| Urine – what colour, how frequent, do you need to get up in the night to urinate?Defecation – how often, what colour, what consistency, any strong odours, any undigested food? |  |
| Nausea/vomiting? |  |
| Acid reflux/ Indigestion? |  |
| Drinks (do you prefer warm/cold?) |  |

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| Aversion to hot/cold temperature/weather |  |
| Sweating (day/night) |  |
| Headache (location and frequency) |  |
| Dizziness  |  |
| Nausea / vomiting  |  |
| Joints/muscular pain  |  |
| Alcohol use |  |
| Smoking  |  |
| Drugs / joints use |  |
| Accident/trauma  |  |
| Tiredness  |  |
| Stress levels |  |
| Emotional situation |  |
| Eyes: dry, itchy, poor sight, floaters, painful, tension etc. |  |
| Ears: Tinnitus / deafness  |  |
| Smell: Notice any particular smells/aversion to? |  |
| Taste: Special taste in mouth in the morning? |  |
| Complexion (pale/red) |  |
| Heart beat rate (fast, slow, irregular?) |  |
| Other information if any (hair loss, nails, skin etc.) |  |
| Other concerns which you think are important    |  |