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 /appetite  Any 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?) |  | | |

|  |  |
| --- | --- |
| 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 |  |