Intake Form: Teens (Male) Heavenly Star Acupuncture

|  |  |  |
| --- | --- | --- |
| Name: | | Date of birth: |
| Siblings: | | Parent: |
| Telephone: | |  |
| Address: | | |
| 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, operations and medicine use** |  | |
| Any family diseases? |  | |
| Results of examinations by western medicine doctors? |  | |
| **General information** | | |
| How well do you sleep (dreams/ nightmare), duration of sleep?  How easy is it to fall asleep, do you wake up often in the night?  How do you feel when you wake up? Rested etc.? |  | |
| Diet /appetite  Restrictions/ intolerances  Digestion |  | |
| Urine – what colour, how frequent, up in the night to urinate?  Defecation – how often, what colour, what consistency, any strong odours, any undigested food?  Constipation?  Loose?  Diarrhoea? |  | |
| Sweating?  Day and /or night? |  | |
| Headache  How often, how strong and where?  Migraine? |  | |
| Dizziness |  | |
| Nausea / vomiting |  | |
| Joints/muscular pain |  | |
| Accident/trauma  (broken bones/shocks) |  | |
| Tiredness |  | |
| Emotional situation |  | |
| Aversion to cold / hot |  | |
| Eyes: dry, itchy, poor sight, discharge, glasses etc. |  | |
| Ears: Ringing in your ears/buzzing, deafness etc. |  | |
| Nose: Blocked, runny, notice any particular smells etc. |  | |
| Allergies? |  | |
| Motor skills? |  | |
| Complexion (pale / red) |  | |
| Heart beat rate (fast, slow, irregular?) |  | |
| Sports: |  | |
| Other information if any (hair loss, nails, skin etc.) |  | |
| Other concerns which you think might be important? |  | |