Intake Form: Teens (Male) Heavenly Star Acupuncture

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| --- | --- |
| 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/ intolerancesDigestion |  |
| 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?   |  |