**Intake form:**

Women

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: | | | Date of birth: | |
| Gender: | | | Relationship status: | Children: |
| Address: | |  | | |
| Email: | |  | | |
| Telephone: | |  | | |
| Occupation: | |  | | |
| **Chief complaint (describe it in detail)** | |  | | |
| Since? | |
| 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 (eg heart disease, diabetes, hypertension etc)** | |  | | |
| Any family diseases? | |  | | |
| Results of examinations by western medicine doctors? | |  | | |
| Method of contraception?  Menstruation – regular/irregular/stopped?  Cycle length?  (between the bleeds)  Heavy/scanty bleeding?  Number of days?  Dark or light in colour?    Blood clots?  Pre-menstrual stress?  Period pains/cramps?  Vaginal discharge? colour, odor, amount etc.  Any previous gynaecological diseases or operations?  History of pregnancy?  Miscarriage? | |  | | |
| **General information** | | | | |
| How well do you sleep (dreams/nightmare), duration of sleep etc? |  | | | |
| Diet /appetite |  | | | |
| Digestion  Any nausea/vomiting, gurgling, indigestion, acid reflux, bad breath? |  | | | |
| Urine – what colour, how frequent, do you need to get up in the night to urinate?  Defecation – how often/daily, what colour, what consistency, any strong odours, any undigested food? |  | | | |
| Drinks (prefer warm/cold?) |  | | | |
| Aversion to cold / hot temperatures/weather? |  | | | |
| Sweating (day/night) |  | | | |
| Headache (location) |  | | | |
| Dizziness |  | | | |
| Joints/muscular pain |  | | | |
| Stress levels |  | | | |
| Alcohol use |  | | | |
| Smoking |  | | | |
| Drugs / joints use |  | | | |
| Accident/trauma |  | | | |
| Tiredness |  | | | |
| Emotional situation |  | | | |
| Eyes: dry, itchy, poor sight, floaters, painful, tension etc. |  | | | |
| Ears: tinnitus / deafness? |  | | | |
| Smell: notice any particular smells? |  | | | |
| Taste: Any special taste in the mouth on waking? |  | | | |
| Heart beat rate (fast, slow, irregular?) |  | | | |
| Complexion (pale/red) |  | | | |
| Other information if any (hair loss, nails, skin etc) |  | | | |
| Other concerns which you think are important to share |  | | | |