**Intake Form**

**Teens**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | | | Date of birth: |
| Gender: | | | Siblings: |
| Parent: | | | Telephone: |
| Address | | | |
| Email: | | | |
| **Chief complaint (describe it in details)** | |  | |
| Since when? | |
| Any treatment/therapy or medicine?  Any progress?  Anything which relieves or worsens the situation  ? | |
| Has it happen 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:** |  | | |
| Menstruation – regular/irregular  When did it start?  Cycle length?  (between the bleeds)  Heavy/scanty bleeding?  Number of days?  Dark or light in colour?    Blood clots?  Pre-menstrual stress?  Moodiness/emotional swings?  Period pains/cramps?  Vaginal discharge? colour, odor, amount etc.  Method of contraception?  Any previous gynaecological diseases or operations?  History of pregnancy? |  | | |
| 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  Any nausea/vomiting, gurgling, indigestion, acid reflux, bad breath? |  | | |
| 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?  Diarrhea? |  | | |
| 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 Stress levels? |  | | |
| Aversion to cold / hot weather/room temperatures? |  | | |
| 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? |  | | |