Intake Form: Men Heavenly Star Acupuncture

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 heavenly star acupuncture