Intake Form: Pregnancy Heavenly Star Acupuncture

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: | | | Date of birth: | |
| Months pregnant: | | | Partner Status: | Children: |
| Occupation: | | | Phone: | |
| Address: | |  | | |
| Email: | |  | | |
| Preferred place of birth? | |  | | |
| Midwife  Doula | |  | | |
| Other support | |  | | |
| Exercise | |  | | |
| **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 (e.g. heart disease, diabetes, hypertension etc.)** | |  | | |
| Any family diseases? | |  | | |
| Results of examinations by western medicine doctors? | |  | | |
| Pregnancy to date? | |  | | |
| Previous pregnancies? | |  | | |
| Pregnancies in the family | |  | | |
| Gynaecological operations/conditions | |  | | |
| **Previously:**  Method of contraception?  Menstruation – regular/irregular/stopped?  Cycle length?  Heavy/scanty bleeding?  Dark or light in colour?    Blood clots?  Pre-menstrual tension?  Period pains?  Vaginal discharge? colour, odor, amount etc. | |  | | |
| **General information** | | | | |
| How well do you sleep (dreams/nightmare), duration of sleep, waking rested etc.? |  | | | |
| Diet /appetite  (vegan/vegetarian/ intolerances?) |  | | | |
| Digestion?  Acid reflux/indigestion |  | | | |
| 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? |  | | | |
| Drinks (prefer warm/cold?) |  | | | |
| Aversion to cold/hot weather/temperatures |  | | | |
| Sweating (day/night) |  | | | |
| Headache (location) |  | | | |
| 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 |  | | | |
| Smells: Notice any  particular smells? |  | | | |
| Taste: Special taste in mouth? |  | | | |
| Heart beat rate (fast, slow, irregular?) |  | | | |
| Other information if any (hair loss, nails, skin etc.) |  | | | |
| Complexion (pale/red) |  | | | |
| Other concerns which you think are important to share |  | | | |