Intake Form: Teens (Female) Heavenly Star Acupuncture

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:	
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? 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 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? heavenly star acupuncture