

Intake Form: Women

Heavenly Star Acupuncture

Name:		Date of birth:
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 (e.g. 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?	

<p>Urine – what colour, how frequent, do you need to get up in the night to urinate?</p> <p>Defecation – how often/daily, what colour, what consistency, any strong odours, any undigested food?</p>	
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.)	
<p>Other concerns which you think are important to share</p> <p>heavenly star acupuncture</p> 	