**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/irregularWhen 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/ intolerancesDigestionAny 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? |  |