Intake form

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| **Client name:** | Date: |
| Address: | Phone: |
| Date of birth: | Email: |

1. Main complaint:

* Short **description** of pain/complaint:
* On a **scale** of 1-10, how is the complaint experienced?
* Where is the pain? Is it radiating elsewhere? **Type of pain** (if applicable)
* **When** did the complaint start? Did it appear gradually? Did the pain complaint change in the course of time?
* Which factors **influence** the complaint?
* What have you done to reduce the complaint (if any)?
* Have you been to a doctor/specialist with your complaints? If so, what was the advice received?
* How do you experience your complaint? Does it have influence on your daily life?

2. Secondary /sub complaints:

## 3. Medical history/ hereditary diseases:

* Have you had any **sicknesses** in the past? Have you been hospitalized before? If so, when and for what?
* Do you take any **medicine**?
* Do you have any **allergies**?
* Are there any conditions/**diseases** running **in the family**?

4. Emotional life events (anything 1.5-2 years before the complaint started)?

## 

## 5. General questions

* Do you **smoke**? If so, how much and since when?
* Do you drink **alcohol**? If so, how much and since when?
* How much **coffee** do you drink per day?
* Do you use any **drugs**? If so, how much and since when?
* What do you do for **work**?
* What do you do in your **free time**/hobbies?
* Are you in a **relationship**?
* Do you do **sports**? If so, how often per week?
* How is your diet? Any special diet(/dairy products)? How often do you eat sweets/snacks?
* What are your **expectations** from this treatment?

## 7. Chinese and overall anamnesis

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| Do you often feel **cold** (chilled) or rather **warm**? |  |
| Do you often have **cold hands** or feet? |  |
| Do you **sweat** easily? If so, when, during the day? |  |
| How often do you have **headaches**? |  |
| What sort of headache is it? When (on a day or in a month) do you have it most often? |  |
| Do you have a **bloated feeling** or pain in your stomach? Is your complaint getting better or worse after eating? |  |
| Do you ever suffer from **cystitis**? Do you often need to urinate? |  |
| Do you have a regular **stool**? Do you suffer from constipation/diarrhea? |  |
| Do you suffer from **insomnia**? |  |
| If so, do you have a problem wih falling asleep, waking up at night or waking up too early? How often? Do you have a lot of dreams? |  |
| How is the condition of your **eyes**? Do you wear **glasses**? |  |
| How is your **hearing**? |  |
| How much liquids do you **drink** a day? Do you often feel thirsty during the day? Do you prefer hot or cold drinks? |  |
| Do you have **restless legs**? Do you suffer from cramps or tingling, pain? |  |
| **Lungs**: do you have shortness of breath/asthma/ bronchitis? |  |
| **Heart**: do you have low/high blood pressure/arrhythmia? |  |
| **Energy** level (1-10): Do you often feel **tired**? If so, when? |  |
| Do you experience any **emotion** more regularly? E.g. anxiety or anger |  |
| For women |  |
| When did you have your **1st period**? |  |
| Do you have a **regular** period? How long is it? |  |
| Do you have PMS or other complaints? |  |
| How many **pregnancies** did you have and with what outcome? |  |
| Are you in **menopauze**? Do you experience complaints related to it? What are those? |  |