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**INTAKE QUESTIONNAIRE**

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| **Name:**  | **Date of birth:**  |
| **Relationship status, children:**  | **Occupation:** |  |
| **Address** |  |
| **Mobile** |  |
| **Email** |  |
| Your **insurance provider and insurance number** |  |
| **Your MAIN COMPLAINT(S)** and how long do you have these problems? |  |
| In case of **PAIN** | What kind of pain is it: * FIXED/WANDERING
* 1-SIDED or BOTH-SIDED
* SEVERE/DULL
* RELIEVED/AGGREVATED by exercise or movement
* More pronounced in the MORNING/ EVENING, NIGHT
* Feels BETTER/WORSE upon pressure or massage
* Is it relieved by WARMTH/COLD?
* In case of headaches, at which part of the head is it?
 |
| Do you know what could be the **cause**? |  |
| What **treatment** did/do you get for your problem(s)? Did you have any medical exams related? |  |
| A **history** of other illness, surgery, injury, trauma etc.? |  |
| Are you taking any **medications**? |  |
| How is the **health of your parents?** |  |
| How is your **appetite**?  | -How many meals per day do you have?-Do you think your diet is healthy? -Do you have any special diet?-Any restrictions? Food allergies? |
| Do you often feel **thirsty**? | -Do you drink enough water?-Do you prefer cold or warm, hot beverages?-How many cups of coffee, green/black tea do you drink per day?-Are you thirsty in the night? |
| **Taste** - cravings | Sweet / Salty / Sour / Bitter / Spicy |
| **Bowel movement:** | -is it regular?-are stools more loose, unformed or hard, constipated? |
| **Urination:** |  -is it frequent?-what color is it: more clear or dark, turbid?-is the quantity more scanty or copious? -do you need to urinate in the night? |
| Feeling of **temperature** | -Are you prone to feeling more **cold or warm/hot**? -Do you like to wear many layers?-Are you sensitive to temperature change? |
| Do you **sleep** well? | -When do you usually go to bed?-How many hours do you usually sleep?-Do you think you have a quality sleep? -When you wake up in the morning do you feel refreshed?-Do you have troubles falling asleep?-Are you waking up in the night?  |
| **Energy levels**  | -What are your energy levelsbetween **1 and 10?**-Do you often feel tired “without a reason”?-Do you feel that you work too much?-Do you have enough time for yourself?-Are you satisfied with your lifestyle?-After moving, do you feel more energy or less? |
| **Stress Level**  | - What is your stress levelbetween **1 and 10?**-How are you dealing with stress? |
| - Do you smoke?- Do you drink alcohol excessively? |  |
| **Emotions** | *Which of the following emotions (or some other) are prevalent in you*:Anxiety / FearAnger, Frustration DepressionWorry Irritability SadnessOverthinkingOverjoy/excitement-Are you good at expressing your emotions? |
| **Exercise** | -No Exercise-Mild Exercise *(active increase in heart rate more than 2 times a week)*-Moderate Exercise *(Less than 4x week for at least 30 minutes)* *-*Intensive Exercise *(4 or more times a week for more than 30 minutes)*What kind? |
| How are your **memory and concentration?** |  |
| If you are **menstruating**: | - When did you get your 1st menstruation?- Is your menstruation regular/irregular/stopped? - How many days? - Heavy/scanty bleeding? -Dark or light in color? -Blood clots?-PMS?- Period pains/cramps:**-Vaginal discharge**: If yes, please indicate color, odour, amount etc. - Any previous gynaecological diseases or operations?-History of pregnancy: -Miscarriage:-Method of contraception: |
| If you are a female: Are you pregnant? |  |
| Do you have a pacemaker? |  |
| Please add here anything that you feel is important for me to know |  |

PLEASE NOTE:

1. Certain acupuncture points are contradicted during pregnancy, therefore the patient must take this into consideration during their treatment (if they are pregnant or are planning a pregnancy). It is the responsibility of the patient to communicate this to the therapist.
2. It is recommended **not to have a treatment on an empty stomach**.
3. Wear comfortable clothing.
4. Cancellation policy: at least 24 hours in advance.
5. Please make sure to check your spam mailbox in case you receive no reply from me within two working days.

Please send this form **at least 1 day prior to your visit** via email to contact@aleksandraacupuncture.nl

**THANK YOU for trusting me with your health!**

 