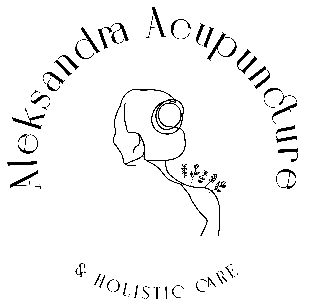
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**INTAKE QUESTIONNAIRE**

|  |  |  |  |
| --- | --- | --- | --- |
| **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 / Fear  Anger, Frustration  Depression  Worry  Irritability  Sadness  Overthinking  Overjoy/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](mailto:contact@aleksandraacupuncture.nl)

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

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