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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? |  |
| 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**  | −between **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**  | −between **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. On your first visit, you should bring your medical insurance card with you.
3. It is recommended not to have a treatment on an empty stomach.
4. Wear comfortable clothing.
5. Cancellation policy: at least 24 hours in advance, by phone, otherwise you will be charged for the appointment.
6. 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!**