PATIENT INTAKE FORM

Please answer the following questions to the best of your ability to enable a more complete assessment of your condition.

Date: _____ Name: _____

Address_____ Suburb: _____ Post Code:_____

Work #: _____ Home #: _____ Mobile: _____

Sex: _____ Marital status: _____ Height: _____ Weight: _____

D.O.B: _____ Occupation: _____ Health Fund: _____

E-mail address: _____

How were you referred to Acupuncture Emporium?

- Friend ____
- Relative ____
- Other Health Practitioner

  _____
- Website
  - Acupuncture Emporium
  - Indigo Health for Mind & Body
  - Natural Therapy Pages
- Other_____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____Suburb & Post Code: _____

Home #: _____ Work #: _____ Mobile: _____

Doctor and/or Specialist:

_____

_____

_____

Main Complaint: _____

DRUG ALLERGIES

Are you allergic to any medications that you know of? Yes _____ No _____

Medication	Reaction

CURRENT MEDICATIONS/HERBS OR SUPPLEMENTS

Are you currently taking any medications/herbs or supplements? Yes _____ No _____

Medication	Dose	Frequency

ILLNESS HISTORY

Please mark conditions that you currently have or have had in the past.

Condition	Y	N	Comments
Diabetes			
Heart disease			
High blood pressure			
Kidney disease			
Arthritis			
Cancer			
Birth defects			
Bowel Disease			
HIV/AIDS			
Thyroid disease			
Lupus erythematosis			
Blood disorders			
Anxiety/Worry			
Asthma			
Anaemia			
Hepatitis			
Epilepsy			
Headaches			
Other			

SOCIAL HISTORY

Do you use tobacco?	Yes _____	No _____	#Packs/day _____
Do you use alcohol?	Yes _____	No _____	#Drinks/wk _____
Do you drink caffeinated drinks?	Yes _____	No _____	
Have you ever smoked Marijuana?	Yes _____	No _____	
Have you ever taken 'recreational' drugs?	Yes _____	No _____	

CURRENT & PAST OCCUPATIONS

Please list your current and previous occupations especially if any of these included you being exposed to chemicals etc.

_____

_____

FEMALE GYNECOLOGIC HISTORY

At what age did you commence menstruating?	_____
When was the first day of your last period?	_____
Are your periods regular?	Yes _____ No _____
Have you ever needed medication to bring on your period?	Yes _____ No _____
How many days do you bleed?	
Which day (or days) is your heaviest day of bleeding?	
Do you use:	Tampons /Sanitary Pads /Both
On the Heaviest Day of bleed how many tampons or sanitary pads would you use?	Day: _____ Night: _____
Pain with menstruation?	Yes _____ No _____
Where is the pain located (i.e headache, breasts, lower back, lower abdomen thighs and legs)	_____ _____
Degree of pain:	_____
Pain relieved by over the counter meds?	Yes _____ No _____
Starts with the onset of bleeding?	Yes _____ No _____
Begins a few days prior to onset of bleeding?	Yes _____ No _____
Persists more than 48 hours?	Yes _____ No _____
Do you notice clotting in your menstrual blood?	Yes _____ No _____ If yes how big are the clots? - 5c piece or smaller - 10c piece - 20c piece - 50c piece or larger
After your menstrual bleed do you experience:	Lower Abdo Pain Yes / No Feel Fatigued Yes / No Get Headaches Yes / No

Do you experience pain with sexual intercourse?	Yes _____ No _____
Pain is mostly on the exterior?	Yes _____ No _____
Pain is mostly internal (deep penetration)?	Yes _____ No _____
Are you experiencing vaginal discharge?	Yes _____ No _____
Associated with itching or burning?	Yes _____ No _____
Associated with an unusual odor?	Yes _____ No _____
Do you have a Gynecologist?	Yes _____ No _____
When was you last Pap Smear?	_____
Result?	_____
Have you ever had an abnormal Pap Smear?	Yes _____ No _____
If yes, what follow up was needed?	_____
Have you ever had a Mammogram?	Yes _____ No _____
Have you ever had a sexually transmitted disease? (i.e. Chlamydia, Gonorrhea, Syphilis, Herpes, Genital Warts, Fungal Infections)	Yes _____ No _____
When?	_____
Was it treated?	Yes _____ No _____
Have you ever had Pelvic Inflammatory Disease (PID)?	Yes _____ No _____
When?	_____
Were you Hospitalized?	Yes _____ No _____
Do you experience milk or discharge from your breasts?	Yes _____ No _____
Do you suffer from vaginal dryness?	Yes _____ No _____
Do you suffer from Bacterial Vaginosis	Yes _____ No _____
Do you have a history of Chronic UTI's?	Yes _____ No _____
Do you have any of the following conditions? (including previous history)	
• Uterine Scarring?	Yes _____ No _____
• Ovarian Cysts	Yes _____ No _____
• Endometriosis	Yes _____ No _____
• Ovarian Faliure	Yes _____ No _____
• Hypothalamic/Pituitary Dysfunction	Yes _____ No _____
• Blocked Fallopian Tubes	Yes _____ No _____
• Blood Clotting Disorder	Yes _____ No _____
- Von Willebrand's	
- Anti-Phospholipid Antibody Syndrome	

Please select the most correct answer/s with regards to your menstruation

- I do not have a period (please move onto miscellaneous section)
- My period is preceded by a day or two of spotting.
- My period is completely regular

- My period is not regular
- My period is less than 5 days: _____
- My period is more than 5 days: My period
- My menstrual blood looks dark and old throughout
- My menstrual blood looks fresh and health throughout
- My menstrual flow starts clotty with dark blood, but the blood gets fresher as the flow continues
- My menstrual blood gushes at the beginning
- My menstrual blood is very thick
- My menstrual blood is very watery
- Towards the end of my period my menstrual blood look like soy sauce

Ovulation or the middle of your cycle

- Do you know whether you ovulate? Yes _____ No _____
- Do you have pain with ovulation or around the middle of your cycle? Yes _____ No _____
- Do you experience mucus discharge, mid cycle, that looks and feels like egg white? Yes _____ No _____
- Do you notice an increase in your sex drive around the middle of your cycle? Yes _____ No _____

Last week of your cycle

- Does your partner tell you or do you feel that you are irritable or cranky? Yes _____ No _____
- Do you experience headaches? Yes _____ No _____
- Do you experience back/neck tension? Yes _____ No _____
- Do you retain fluids? Yes _____ No _____
- Do you have trouble sleeping? Yes _____ No _____
- Do you experience diarrhea / loose stools Yes _____ No _____
- Do you experience constipation Yes _____ No _____

MISCELLANEOUS

1. Do you bleed between periods: Yes _____ No _____
2. Do you ever experience abnormal vaginal discharge (not associated with ovulation)? Yes _____ No _____

3. Has your (male) partner had a semen analysis and reproductive health check completed recently? Yes _____ No _____

   Results:

   Date _____
   Count (Million cell/ml) _____
   Motility (%) _____
   Morphology (% normal forms) _____
   Other _____

PREVIOUS SURGERIES

Have you ever had surgery?

Procedure	Date	Indication	Outcome

CONTRACEPTION

Have you ever used any of the following forms of contraception previously?

1. Oral Contraceptive Pill Yes _____ No _____

   When: _____

   Name of Pill: _____
2. Intra Uterine Device Yes _____ No _____

   When: _____
3. Implanon Yes _____ No _____

   When: _____
4. Depo Provera Yes _____ No _____

   When: _____

OBSTETRICAL HISTORY

Have you ever returned a positive pregnancy test? Yes _____ No _____

If no please go to the next section:

- How many times have you been pregnant? _____
- How many children have you had? _____
- How many miscarriage have you had? _____
- How many pregnancies have you had terminated? _____
  - Surgical termination: Yes _____ No _____
  - Medical termination: Yes _____ No _____
- Were any of your pregnancies ectopic: Yes _____ No _____
- Did any of your pregnancies have a premature delivery: Yes _____ No _____
- Were your births:
  - Vaginal: Yes _____ No _____ Comments: _____
  - C-Section: Yes _____ No _____ Comments: _____

GENETIC HISTORY

Is there any of the following active in your family that you are aware of?

- General chromosomal disorders Yes _____ No _____ Comments: _____
- Down's Syndrome Yes _____ No _____ Comments: _____
- Cystic Fibrosis Yes _____ No _____ Comments: _____
- Kallman's Syndrome Yes _____ No _____ Comments: _____
- Turner's Syndrome Yes _____ No _____ Comments: _____

GYNAECOLOGICAL INVESTIGATIONS

1. Has a Doctor completed a physical examination of your external genitals?
   Yes _____ No _____
2. Have you recently had detailed blood work done?
   Yes _____ No _____ (If yes can you supply copies)
3. Have you had any Ultrasound completed: Yes _____ No _____
   - Vaginal
   - Abdominal
4. Have you had an HSG (Hysterosalpinogogram) completed?
   Yes _____ No _____
5. Have you had a laparoscopy or other investigative surgeries?
   Yes _____ No _____

ASSISTED REPRODUCTION

Have you undertaken any of the following procedures:

1. Timed intercourse Yes _____ No _____
2. Ovulation stimulation with Clomid Yes _____ No _____
   - Including IUI (Intra Uterine Insemination) Yes _____ No _____
3. Ovulation stimulation with pituitary hormones (Gonal-F, Puregon) without IVF
   Yes _____ No _____
   - Including IUI Yes _____ No _____
4. IVF (Including ICSI or PICSI) Yes _____ No _____

Please list the number of cycles and their outcome

_____
_____
_____
_____
_____
_____
_____

I consent to have Acupuncture and if required also cupping, gua sha and prescribed Chinese herbal medicines based on a traditional Chinese medicine diagnosis but incorporating Western Medicine diagnosis, use of pathology tests and knowledge of the latest research into Chinese medicine and acupuncture.

After acupuncture treatment it is possible but uncommon that you may experience tenderness, minor bleeding and/or bruising at the needle sites. It is also possible that you may feel light headed, some dizziness, a feeling of elation, calm or emotional. The use of Cupping and/or Gua Sha can also leave the area feeling tender and produce either redness or bruising at the site.

Name: _____ Signature: _____

Date: _____