**Acupuncture/Chinese Medicine Intake form**

**Sue Sun Holistic Health Clinic**

**104 Tamahere Drive,Glenfield,Auckalnd**

**Booking number:0212614021**

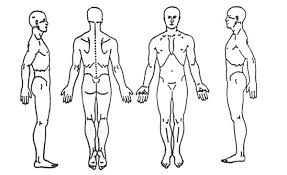
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| --- | --- | --- | --- |
| Name |  | Date of Birth |  |
| Phone Number |  | Occupation |  |
| Address |  | | |

**I would like to receive the information in the future regarding promotion via**

**Mobile: \_\_\_\_ or Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I don’t want to receive any information \_\_\_\_\_\_\_**

**Do you hold ACC claim number for any injury within 1 year: Yes\_\_\_\_\_\_ NO\_\_\_\_\_\_ ACC 45 Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I often feel sore/ stiff / pain /numbness/tingling /cramps on these areas (circle the area)**



|  |  |  |  |
| --- | --- | --- | --- |
| Questions | Yes | No | Specify |
| Have you Tried Acupuncture before? |  |  |  |
| Do you have a contagious disease at this time? (E.g. Hepatitis, TB, HIV etc.) If yes, please specify. |  |  |  |
| Have a pacemaker or any other electrical implants |  |  |  |
| Have a bleeding disorder/any addictions/Allergies |  |  |  |
| Have damaged heart valves or have any other particular risk of infection |  |  |  |
| Are pregnant |  |  |  |
| **Any Current Medications/Supplements :Name\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_**  **Name\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Major complaints and onset date | Level of pain scale or uncomfortable feelings  (0 no pain/best feeling--**10** worst pain/feeling) | Your expectation  from our treatment? |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |

**I’d like to get**[ ] **Temporary relieve treatment-short term with a specific health condition that I have.**

[ ] **long term maintenance-Help with most of my health symptoms that I have**

**We will try other methods when the treatment result hasn’t reached your expectation,**

**Discuss with your practitioner before your cancellation,please.**

1. **Frequency for Acute conditions: 2-3 times/week for first 3 weeks, up to 6 sessions treatment.**

**After that Continuation of the treatment as maintenance is also important after your condition is improved**

**Once a week/every 2 weeks/once a month depends on your condition**

1. **Try to relax yourself both physically and mentally.**
2. **Healthy Diet - less junk food, sweet food, spicy food or meat.**
3. **If you can’t afford the cost, let us know.(private:$65-$90/session, ACC:$30 herbs:$15-$130/week)**
4. **You don’t have to cancel your appointment when you feel sick or flue(unless you need to go to Emergency),as we can use our Chinese herbs Medicine to help you with these symptoms.**

|  |  |  |
| --- | --- | --- |
|  | **private** | **ACC for injury within 1 year(45mins-1hour)** |
| Fees | $85 to $90 ——1hour \_\_\_\_  S120——90mins\_\_\_\_\_ \_  $65——45mins\_\_\_\_\_\_\_\_\_other fee please see the price sheet on the reception | Casual:$30-1hour\_\_\_\_\_\_ \_  ACC with other condition 15mins extra 20$\_\_\_\_\_\_ |
| My payments will be covered by my health insurance \_\_\_\_\_\_\_\_\_ | | |

**If you only want to get pain management, please skip the followings question.**

**There are 2 pages all together.**

**Please tick the symptoms you have if you want to get treatment about Women’s health\_\_\_\_**

**Men’s health\_\_\_\_\_ Internal problems\_\_\_\_ Emotional problems\_\_\_ Skin issue\_\_\_\_ .**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **System** | | **Classification** | | **Signs and Symptoms** |
| **Heart**  **& Lung** | | **Cough** | | □Frequent □Persistent □Dry  what time do you feel worse:□( )AM □ ( )PM □During Sleep |
| **Sputum** | | Texture: □clear □turbid  Smell: □smelly □normal  Colour：□clear □white □light yellow □yellow □whitish yellow  □green □brown □dark □with blood  □profuse □Easy to spit □not easy to spit |
| **Breath** | | □Shortness of breath □Rapid breathing □Long exhale and short inhale □wheezing |
| **Chest** | | Location; □Left □Right □Centre  □Pain □Swelling □Chest fullness □Itchy □Redness □Swollen  □Sweating □Palpitation |
| **Digestion** | | **Taste/Oral conditions** | | □Light-tasted □Sourness □Bitterness □Sweetness □Saltiness □Dryness  □Sticky □Bad breath □Recurrence oral ulcer;  What time does your mouth feel bitter?□ ( )AM□ ( )PM □During Sleep |
| **Thirst** | | Preferred drink: □cold water □Warm water  □Wanting to drink when feeling thirsty  □Feeling thirsty but not wanting water  □Still feeling thirsty no matter drinking how much water  □What time do you feel thirsty?: □( )AM □ ( )PM □During Sleep |
| **Food/appetite** | | □Feeling hungry but not wanting to eat; □poor appetite □good appetite  □Feel hungry easily and eat plenty |
| **Food preference** | | □Sour □bitter □sweet □spicy □salty □warm □cold □deep fried  □Light-flavoured □dry food |
| **Vomiting** | | Texture：□clear □turbid □smelly □vomiting blood  □Vomit right after eating; □Vomiting in the evening □Vomiting in the morning  □Nausea only;□Vomit undigested food |
| **Stomach/ epigastric area** | | □Feeling cold □ Feeling warm □Pain □Distended □acid □reflux  □bloating □cramping □Nausea □Heartburn |
| **Abdomen** | | □Feeling cold □ Feeling warm □Pain □Distended □Bloating □Cramping  □Refuse pressure on abdomen □Like pressure on abdomen □abdominal varicose veins |
| **Dry stool (formed)** | | □Foul odour □bloody stool □sausage-shaped □small circular shaped  Frequency:pass every ( )days |
| **Watery Stool-(unformed)** | | Texture：□clear □turbid □Foul odour □green colour □bloody stool Frequency: how many times per day?( )times □indigested food  □firstly dry and then watery □Diarrhea in the morning □Incontinence  □Passing with burning sensation |
| **Gas** | | □Foul odour □odourless □frequency |
| **Anus** | | □Pain □Swelling □Itchy □Red □Swollen □dry □lumpy □Has pus □bleeding □Hemorrhoids □Rectal prolapse |
| **Liver/Gallbladder** | | **Hypochondriac region** | | □left □right □Feeling cold □ Feeling warm □pain □sore □numbness □swelling □cramping □ gallstone □Hepatitis |
| **Urinary** | | **Urination/smell-colour** | | □Clear □turbid □Foul odour □light yellow □dark yellow □White □With blood |
| **Urination/frequency** | | How many times per day?( )times  How many times during the night sleep (11pm-7am)? ( )times |
| **Urination/volume** | | Flow ( □smooth □difficult □frequent □pain □incontinence □weak □flow □dripping） |
| **Stones** | | □Kidney stone □Bladder stone |
| **Ear Nose and Throat (ENT);**  **Eye (ophthal-**  **mology)**  **Tooth (dental)** | | **Face** | | □Left □right □Feeling cold □ Feeling warm □pain □sore  □numb □swelling □cramping □itchy □red □swollen  □sweating □complexion: □dark □Red □yellow □Pale □Dry  □Facial paralysis |
| **Ears** | | □Left □right □ pain □sore □ numb □swelling □itchy  □red □swollen □frozen bite □pus □Lump □Tinnitus □Deafness |
| **Eyes** | | □Left □right □pain □swelling □itchy □swollen □dry □bleeding  □red eyes □Tearful □Blurred □dark circles □Floaters □vision loss □near-sighted □far-sighted □cataract □glaucoma |
| **Nose** | | □Left □right □pain □itchy □red □swelling □dry □nose bleeding □Sneezing □Snoring □Blockage □No nasal discharge □Turbid discharge  Texture/colour: □clear □White □Yellow □Yellowish white □Green |
| **Throat-larynx** | | □pain □numb □itchy □red □swollen □dry□lump □Difficulty with swallowing □abnormal sensation □hoarse voice |
| **Tooth/gum** | | □Left □right □upper toothache □lower toothache □sore□red swollen □bleeding □teeth grinding |
| **Lips** | | □Pain □itchy □red □swollen □dry □bleeding |
| **Breasts** | | | | □Left □right □ hot feeling □cold feeling □pain □sore □swelling □itchy □red □swollen □Lumpy □Has pus |
| **Sweating** | | | | Texture：□clear □sticky □ foul odour  colour：□clear □light yellow □yellow  □hardly sweating □normal sweating □ frequent sweating |
| **Reproductive**  **(male)**  **Genital** | | | | □Feeling cold □ Feeling hot □Pain □Discomfort □Itchy  □Red □Swelling □Sweaty □Dry □Lump □Pus □Sexually active  □low libido/sex drive □Erectile dysfunction □Premature ejaculation □Nocturnal emission □Hernia |
| **Dermatology** | | **skin** | | □Feeling cold □ Feeling hot □Pain □Numb □Itchy □Red □Swelling □Pus □Dry □Lump □Bleeding □Bruise □Spot □Rash  Texture: □Scaly □Blisters □Pitting with pressure |
| **Hair** | | Amount: □Sparse □Abundant Texture: □thick □thin □Dry □Oily  Colour：□Normal □White  Hair loss: □Top □side □back □front □all |
| **Fingernails** | | □Grey □Dark □Easily broken |
| **Toenails** | | □Grey □Dark □Easily broken |
|  | | **Saliva** | | Texture: □clear □turbid Colour: □clear □white □light yellow  Volume:□Difficulty with secreting □Drooling during sleeping |
|  | | **Sleep-general** | | Sleep ( )hours/day □ Insomnia □Sleepiness □Shallow sleep  □Difficulty falling into sleep □Easy to get back to sleep after waking □Excessive Dream □Feeling refreshed when woken-up |
| **Sleep-insomnia** | | □Feel sleepy between 9pm-11pm □Wake up between 11pm-1am □Wake up between 1am-3am □Wake up between 3-5am |
|  | | **General brain function** | | □Hyperactive □Calm □Memory loss |
|  | | **Emotions** | | □Joy □Anger □Worry □Over-thinking □Sorrow □Fear □Short-tempered □ grief □Anxious □Impulsive □quick-tempered □Depressed |
|  | | **General personalities** | | □Extroverted □ Introverted □Introverted and extroverted □Generous □Passionate □Lonely □Out of touch □Attentive □Discipline □Confident □Perseverance □Timid □Lack of determination □Stubborn □ Suspicious □Fickle □Tolerant □Bold □Decisive □Patient |
| **Body part classification** | | | | |
| **Head** | **Frontal** | | □ cold feeling □ hot feeling □ pain □sore □numb □tightness □cramping  □itchy □ red □swollen □sweating □Dry □Bleeding □Vertigo | | |
| **Temporal** | | □Left □right □ cold feeling □ hot feeling □ pain □sore □numb □tightness □cramping □itchy □ red □swollen □sweating □Dry □Bleeding □Vertigo | | |
| **Occipital** | | □ cold feeling □ hot feeling □ pain □sore □numb □tightness □cramping  □itchy □ red □swollen □sweating □Dry □Bleeding □Vertigo | | |
| **Parietal-**  **top** | | □Left □right □ cold feeling □ hot feeling □ pain □sore □numb □tightness □cramping □itchy □ red □swollen □sweating □Dry □Bleeding □Vertigo | | |
| **Neck** |  | | □Pain □sore □numb □tightness □cramping □itchy □red □swollen □ sweating; | | |
| **Upper limbs** | **Shoulders** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising | | |
| **Arm pits** | | □Left □Right □itchy □red □sweaty due to heat □foul odour | | |
| **Elbows** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising | | |
| **Arms** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising | | |
| **Wrists** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising | | |
| **Fingers** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising | | |
| **Dorsum** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising | | |
| **Palms** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising □sweating | | |
| **Lower limbs** | **Buttocks** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising | | |
| **Thighs** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising | | |
| **Knees** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising | | |
| **Lower legs** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising | | |
| **Ankles** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising | | |
| **Feet** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising | | |
| **Toes** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising | | |
| **Plantar** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising □sweating | | |
| **Back and low back** | **Upper back** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising □Sweating | | |
| **Middle**  **back** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising □Sweating | | |
| **Low back** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising □Sweating | | |
| **Sacrum** | | □Left □Right □pain □sore □numb □tightness □cramping □itchy  □red □swollen □bruising □Sweating | | |
| **Body shape** | | | Weight:\_\_\_\_\_\_\_\_\_\_kg Height: \_\_\_\_\_\_\_\_\_\_m BMI: \_\_\_\_\_KG/\_\_\_\_\_m²=\_\_\_\_\_\_  □Obesity≥ 30.0 □Overweight:25. 0 – 29 9  □Healthy weight range: 18.5 – 24.9 □Underweight≤ 18 4 | | |

**Gynaecology**

|  |  |
| --- | --- |
| **General info** | First occurrence of menstruation ( ) Y  Menstruation/Period Cycle: ( )days Length of cycle: ( )days  □Early period □Normal Cycle (approximately 28 days)  □Delayed period □Irregular period for ( ) cycles |
| **Menses details** | Volume: menopause(more than 3 months in a row not pregnant)  □Quantity profuse: Over 100ml per day  □Normal: about 50ml  □Scanty: Less than 30ml  Colour of blood: □Dark purple □Dark red □normal □fresh red □pale/light red  Bleeding with clots？ □ Yes □ No  Clots □ large size □Small size □No clot □large amount □small amount  Bleeding between two cycles □Yes □ No |
| **Signs and symptoms** | □Before □during □after the cycle:  □Breasts tenderness  □Lower abdomen: bloating/pain/cramping Duration:( )days  Applying pressure to the lower abdomen when feeling discomfort:  □Feeling better □Feeling worse  With heat applied on the lower abdomen when feeling discomfort:  □Feeling better □Feeling worse  During the period: □Feeling chill □Fever □Hot flushes□Nose bleeding □Pimples increase in number before period and fade away after period □Headache □Dizziness □Diarrhea □Chest fullness □Nausea □Anxiety □Short-tempered  Low back pain/sore/cramping: □Yes □No  Pain/soreness/cramping scale: □Severe □Moderate □Mild □No pain  When does the pain/soreness/cramping occur: □Before □During □After period |
| **Vaginal discharge** | Normal：□clear □Odourless  Volume: □profuse □ normal □scanty  Abnormal discharge: lasting for how many days ( )days  Colour: □with blood □Yellowish green □Dark yellow □Light □yellow □Normal □Milky □white  Texture: □Spotty □Foamy □Sticky □Moderate □ Egg-white-like □Clear  Smell: □Foul odour □Smelly □Normal  External genital: □Itchy □Cold feeling □Hot feeling □ Swelling □Prolapsed □Pain □Contraction □Burning pain |
| **Obstetric History** | □In a relationship □Y □ N □Number of pregnancy( ) □Miscarriage/Abortion ( )  □How many children did you give birth to? ( )  □How long ago was the last pregnancy? ( )years  Contraception method: □ Pills, □ Minera, □ Copper IUD, □ Depo, □ implant, □ Condom, □ None of above |
| **Libido** | □Active □Normal □less active □No □Pain during the intercourse |
| **Sex Frequency** | □Active □Normal □Less than average □No |

**Our clinics use only single-use, sterile, disposable needles.**

**Acupuncture can have minor side-effects such as:**

**1.Drowsiness (occurs after treatment in a small number of patients; if affected, you are advised not to drive)**

**2.Minor bleeding or bruising (occurs after acupuncture in about 3% of treatments)**

**3.Fainting (can occur in certain patients, particularly if you get treatment without having meals)**

**I understand that Any treatment given will be explained to me and I have the right to clarify**

**, question or stop the treatment at any time.**

**I have read and understood the above information, and consent to treatment.**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Practitioner only**

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| --- | --- | --- | --- | --- |
|  | **symptoms** | **Acupuncture/other treatments** | **herbs** | **result** |
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