

Patient Intake Form-Pregnancy

**Confidential**

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# Personal Profile

# Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Weeks Pregnant\_\_\_\_\_\_\_\_\_\_\_Due Date\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Single \_\_ Married \_\_ Common-Law \_\_ Divorced \_\_ Children \_\_ Live Alone \_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: home \_\_\_\_\_\_\_\_\_\_\_\_\_ work \_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PC: \_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ In Emergency Notify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Intention

Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Physician’s/ Midwife’s Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other Therapies have you Tried: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How Long has this Condition Existed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you Tried Acupuncture Before: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All Medications Presently Taking (please include pharmaceuticals, vitamins, supplements, herbs):

Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Midwife/Obstetrician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## History of Illness

Childhood: Chicken Pox\_\_\_

German Measles\_\_\_

Whooping Cough\_\_\_

High Fevers \_\_\_

Seizures \_\_\_

Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart : High Blood Pressure\_\_\_ Syst/Dias \_\_\_/\_\_\_

Angina\_\_\_ Arrhythmia\_\_\_ Palpitations\_\_\_ Chest Oppression\_\_\_

Stroke\_\_\_ Heart Murmur \_\_\_

Bleeding Tendencies\_\_\_

Clotting Defects\_\_\_

Varicose Veins\_\_\_

AIDS \_\_\_

Diabetes\_\_\_

Kidney Trouble\_\_\_

Hepatitis/ Jaundice \_\_\_ A,B,C?

Epilepsy \_\_\_ Seizures \_\_\_

Cancer\_\_\_

Arthritis (rheumatic, osteo)\_\_\_

Colitis\_\_\_ IBS\_\_\_

Asthma\_\_\_ Short of Breath\_\_\_

Chronic Fatigue/Epstein Barr\_\_\_

Eating Disorders\_\_\_

Fibromyalgia \_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please List Any Previous Hospitalizations/Operations (include type of operation and date):

### Family Medical History

Alcoholism\_\_\_

Abuse\_\_\_

High Blood Pressure\_\_\_

Cancer\_\_\_

Diabetes\_\_\_

Heart Disease\_\_\_

Osteoporosis\_\_\_

Other Addictions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Illnesses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Lifestyle Profile

How Would You Rate Your General Health:

Excellent Good Fair Poor

10 9 8 7 6 5 4 3 2 1

Do You Have Any Allergies? \_\_\_\_\_\_\_\_\_\_\_

To What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are You A Vegetarian? \_\_\_\_\_\_\_\_\_\_\_\_

Typical Diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Preferences \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Restrictions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Routine Physical Exercise: Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How Long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How Often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Drink Alcohol? \_\_\_\_\_\_\_\_\_ Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Smoke? \_\_\_

How Much? \_\_\_\_\_\_\_\_\_\_\_\_

Previously? \_\_\_\_\_\_\_\_\_\_\_\_

How Long? \_\_\_\_\_\_\_\_\_\_\_\_

Caffeine Use? \_\_\_\_\_\_\_\_\_\_\_\_\_ How Much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mood Altering Substance Use, Past or Present (marijuana, ecstasy, cocaine etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Stress Level**:

Home:

High Moderate Low

10 9 8 7 6 5 4 3 2 1

Work/ School:

High Moderate Low

10 9 8 7 6 5 4 3 2 1

Self:

High Moderate Low

10 9 8 7 6 5 4 3 2 1

**What Mood/Emotion Do You Predominately Experience**:

Happy\_\_\_ Sad\_\_\_ Anger/Irritability\_\_\_Worry/Over Thinking\_\_\_ Frustration\_\_

Anxiety\_\_\_ Fear\_\_\_Depression\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecological History**

List Any Other Pregnancies, Including Miscarriages, or Abortions (Including Date,

How Far Along, Complications, Infections, Loss of Blood, Depression…)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Period History:**

Age of First Period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How Many Days Did Your Period Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount? light / normal / heavy

Color of Blood? red /bright red / purple / diluted / pale / brown

Clots? no / yes: big / small / stringy many / few

**Complications Related to Menstrual Cycle:**

Irritability \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Headaches \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cramping \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fatigue \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Night Sweats \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mood Swings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Distension/Lumps \_\_\_\_\_\_\_\_\_

Unsmooth Flow \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Change in Appetite \_\_\_\_\_\_\_\_\_\_\_\_\_

Water Retention \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did You Bleed Between Periods? \_\_\_\_\_\_\_\_\_\_Any Bleeding Now?\_\_\_\_\_

Sexual Libido? High / Low / Normal

Past Birth Control Method? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Unusual Vaginal Discharge or Itching? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please List Any Other Additional Information That You May Feel Is Relevant

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **Cancellation Policy**;  **Last minute cancellations will be charged** **$95.00**  (or the cost of your service-the lower of the two)  Thank you for your respect and understanding  **24 hours notice is required**  **Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |