

Patient Intake Form-Pregnancy

**Confidential**

**Gigi Vincentine, Dr. TCM. Dip., R. TCM. P., R. Ac.**

# 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…)

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

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

 **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

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

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

|  |
| --- |
| **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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |