**ZENJOY** East Asian Medicine & Acupuncture – Patient Health History Questionnaire

Please help us provide you with a complete evaluation by filling out this questionnaire carefully. All of your answers are strictly confidential. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the Comments section. Thank you!

Name _____ DOB ____/____/____ [ ]M [ ] F [ ] MTW [ ] WTM

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Emergency Contact Name & Phone _____

Physician Name & Phone _____

Whom can we thank for this referral? ☐ Doctor ☐ Online search ☐ ZENJOY event/Health fair ☐ Family/Friend ☐ Other

| Please list your chief complaint(s) for this visit or your condition(s) in order of importance: | Date first noticed: | Indicate the severity of each symptom: None Severe | Please check the box below indicating how much of the time you feel the symptom: |
|---|---|---|---|
| 1. _____ | _____ | 0 1 2 3 4 5 6 7 8 9 10 | ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐76-100% |
| 2. _____ | _____ | 0 1 2 3 4 5 6 7 8 9 10 | ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐76-100% |
| 3. _____ | _____ | 0 1 2 3 4 5 6 7 8 9 10 | ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐76-100% |

**CURRENT LIFESTYLE**

Have you consulted an MD, ND, DO for your reasons for this visit? [ ] Yes [ ] No MD's Diagnosis: _____

Do you exercise regularly? [ ] Yes [ ] No If yes, please describe: _____

List any stress factors (physical, psychological, chemical): _____

Sleep Quality: *Bad* 0 1 2 3 4 5 6 7 8 9 10 *Good* Energy Level: *Bad* 0 1 2 3 4 5 6 7 8 9 10 *Good*

Briefly describe your average daily diet: _____

_____

Please check the following habits that apply. How much and how often do you use them?

☐ Cigarette smoking ☐ Coffee, tea or cola ☐ Alcoholic Beverages

_____ _____ _____

List medications taken within last two months (vitamins, drugs, herbs, etc.):

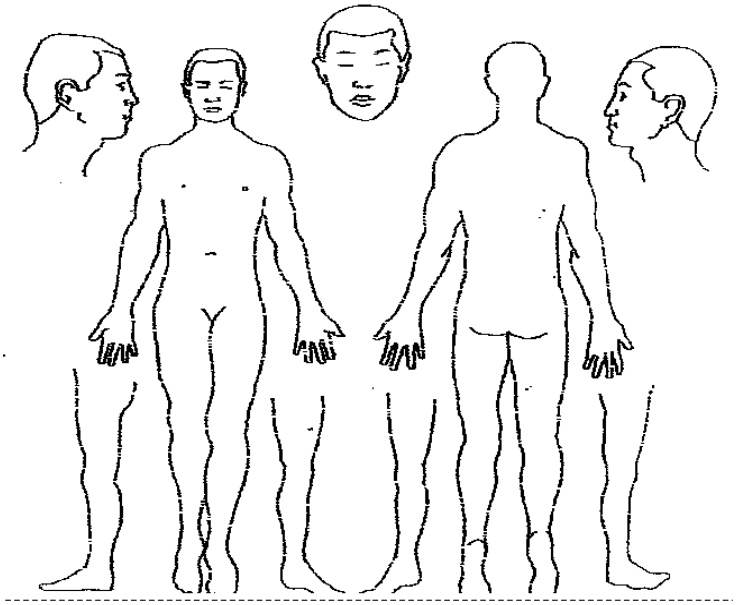
_____

_____

List any drug use for non-medical purposes: _____

Have you ever had any form of counseling, therapy, interventions, etc? [ ] Yes [ ] No If yes, please describe:

_____



Please CIRCLE O any Painful or Distressed areas on the chart on the left. Please describe the pain:

_____

_____

_____

_____

Please MARK X for Scarred areas on the chart on the left. Please describe the scar:

_____

_____

_____

_____

REVIEW OF SYSTEMS

*Please put a mark [X] next to any condition you've experienced in the last three (3) months. Circle all those you've experienced in the past. Indicate the length of time you have had this condition.*

GENERAL

- ☐ Poor appetite
- ☐ Insomnia
- ☐ Disturbed sleep
- ☐ Localized weakness
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Changes in appetite
- ☐ Sweating easily
- ☐ Tremors
- ☐ Bleeding or bruising easily
- ☐ Night Sweats
- ☐ Fever
- ☐ Chills
- ☐ Sudden energy drop
- ☐ Poor balance

SKIN & HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair loss
- ☐ Recent moles
- ☐ Dryness
- ☐ Lesions
- ☐ Changes in texture of hair/skin

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Glaucoma
- ☐ Migraines
- ☐ Glasses
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Eye strain
- ☐ Sinus problems
- ☐ Recurrent sore throats
- ☐ Nose bleeds
- ☐ Grinding teeth
- ☐ Sores on lips or tongue
- ☐ Facial pain
- ☐ Teeth problems
- ☐ Headaches
- ☐ Jaw clicks

CARDIOVASCULAR

- ☐ Nausea/Vomiting
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Difficulty in breathing
- ☐ Phlebitis

RESPIRATORY

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ COPD
- ☐ Bronchitis
- ☐ Pain with deep inhalation
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Difficulty breathing laying down
- ☐ Excessive phlegm
- ☐ Shortness of breath
- ☐ Lung cancer

GASTROINTESTINAL

- ☐ Ulcers
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas/Belching
- ☐ Mucus in stools
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use

GENITOURINARY

- ☐ Pain while urinating
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Decrease in flow
- ☐ Impotence
- ☐ Sores on genitals

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Muscle pains
- ☐ Knee pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Foot/ankle pains
- ☐ Hand/wrist pain
- ☐ Shoulder pains
- ☐ Hip pain

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Dizziness
- ☐ Loss of balance
- ☐ Areas of numbness
- ☐ Poor memory
- ☐ Lack of coordination
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Bad temper
- ☐ Easily susceptible to stress
- ☐ PsychoEmotional issues

**FEMALE ONLY:** REPRODUCTIVE AND GYNECOLOGIC

- ☐ Premenstrual changes
- ☐ Menstrual clots
- ☐ Painful menses
- ☐ Hot flashes
- ☐ Heavy menstrual flow
- ☐ Light menstrual flow
- ☐ Irregular menses
- ☐ Lumps in breast
- ☐ Nipple discharge
- ☐ Premature births
- ☐ Miscarriages ☐ Abortions
- ☐ Other: _____

Is there a possibility you currently may be pregnant? **[ ] Yes [ ] No**

Age at first menses: _____ Age at menopause: _____ Number of pregnancies: _____

Time between cycles: _____ Duration of bleeding: _____ First day of last menses: _____

Do you practice birth control? ____ If so, what type? _____ For how long? _____

**MEN ONLY**

- ☐ Burning with urination
- ☐ Dripping after urination
- ☐ Other: _____
- ☐ Difficulty starting urination
- ☐ Prostate cancer
- ☐ Nightly urination
- ☐ Impotence / ED

PAST MEDICAL HISTORY (Please include dates)

- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Seizures
- ☐ Rheumatic Fever
- ☐ Surgeries
- ☐ Venereal Disease
- ☐ Thyroid Disease
- ☐ Birth Trauma (prolonged labor, forceps delivery, etc.)
- ☐ Heart Disease
- ☐ Suicidal ideation/Suicide attempt
- ☐ Other Significant illness/Trauma (Please describe)

_____
_____
_____
_____

FAMILY MEDICAL HISTORY

- ☐ Allergies
- ☐ Diabetes
- ☐ Asthma
- ☐ Cancer
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Seizures
- ☐ Stroke
- ☐ Other

**ALLERGIES**

List any food sensitivities and allergies, environmental allergies, or other allergy triggers:

_____
_____
_____
_____

COMMENTS

Please list any other concerns you would like to discuss:

_____
_____
_____
_____