Zenliving Patient Initial Intake Form

The following is a confidential questionnaire to determine the best possible treatment plan to suit your health care needs. Please take your time in completing the information and bring the completed form to your initial appointment.

Today's Date: _____

Name:	DOB:
Address:	Apt #:
Phones: -	Cell/Home -
Email:	
Occupation:	
Emergency Contact:	
Relation: Phones: -	Cell/Home
Primary Care Physician:	
Phone:	
Date of last physical/ checkup:	

Do you have Acupuncture benefits through your Health Insurance? **Y/N**

Health Concern you came in to address:
How long has this been a problem?
What medical diagnosis, if any, have you been given for this condition?

Please use the back of the page if more room is needed for any answer. Please indicate that you are using the back of the page with an " * "

What type(s) of past treatments/medical procedures have you tried to address this problem (please include date of treatment or if you are still receiving ongoing treatment)?

List all prescribed pharmaceutical medications/vitamins/supplements/herbal remedies that you are presently taking:

Medication & date began taking	Dosage	Reason
Vitamin/supplement	Dosage	Reason
List any herbs/alternative medicine(s)	Dosage	Reason

List past injuries, broken bones, concussions, car accidents (indicate if anything rendered you unconscious):	Date:

List past surgeries and hospitalizations:	Date:

Professional Work:	How long?

Past Medical History: Please check those diseases that you have experienced in the past or are currently experiencing. Please indicate if the condition is current of if was treated in the past (include dates):

__ Heart Disease	__ Thyroid disease	__ Hepatitis
__ High Cholesterol	__ Diabetes	__ Alcoholism
__ High Blood Pressure	__Drug Addiction	__ Auto Immune Disease
__ Skin Condition type:	__ Colitis/IBS: type:	__ Cancer type:
__Allergies	__Meningitis	Neurological Disease
__Eating Disorder	__Stroke/Vascular Disease	__Mental/Emotional Disorder

Other: _____

Family Medical History: Check any of the following diseases affecting your blood relatives and indicate which relative was affected:

__ Tuberculosis _____
__ Diabetes _____
__ Drug use _____
__ Stroke/vascular disease _____
__ Cancer _____
__ High Blood Pressure _____
__ Heart Disease _____
__ Alcoholism _____
__ Thyroid disease _____
__ Mental/Emotional Disorder _____

Type(s) of cancer:

_____

Other:

_____

What are the major health concerns affecting your parents? If they have passed, how did they die?
Mother:

_____

Father:

_____

What are the major health concerns affecting your grandparents? If they have passed, how did they die?
Maternal Grandmother:

_____

Maternal Grandfather:

_____

Paternal Grandmother:

_____

Maternal Grandfather:

_____

Lifestyle:

Do you drink coffee or black tea? If yes, how much?

_____

Do you drink alcohol? If yes, how much and how often?

_____

Do you currently smoke cigarettes? _____ If yes, how long have you smoked _____
How many cigarettes do you smoke per day? _____ If you no longer smoke, how many years did you smoke and when did you quit?

_____

Do you have a regular exercise program? _____
Please describe the program (include type of exercise, time per session, and #of sessions per week):

_____

_____

Briefly describe your diet (include if you follow a particular kind of diet - e.g. vegetarian, macrobiotic):

_____

_____

_____

How many times a week do you eat out? _____

GENERAL HEALTH -
Please check or circle that which applies and give pertinent information

Teeth/Jaw/Face/Mouth:

Do you have TMJD (TMJ Disorder)/jaw clicking, popping, and/or pain? Yes/No
If so, how long? _____
On which side of the jaw is the pain/clicking more noticeable? _____
Do you grind your teeth at night (Bruxism)? Yes/No
Have you worn braces and/or a retainer? Yes/No
If so, what was your age when you began wearing the braces/retainer? _____
How many years did you wear the braces/retainer? _____
Do you currently wear a retainer or a mouth guard at night? Yes/No
List any dental work/oral surgeries beyond regular teeth cleaning and fillings that you have experienced:

_____
_____
_____

Face:

Pain: Yes/No
Pain Scale: 1-10 _____
Location: _____
Description: _____

Mouth/Lips:

___ Dry mouth ___ Sores on lips/tongue ___ Bleeding gums ___ Swollen gums
___ Dry lips ___ Bad breath ___ Receding gums
Other information:

_____
_____
_____

Headaches/Migraines: Y/N Acute/Chronic

Location(s):

_____

Frequency:

_____

Time of day: _____
Pain Scale: 1-10 _____
Quality of Pain (dull, sharp, heavy etc.):

_____

What relieves pain:

_____

What exacerbates pain:

_____

Other information?

_____
_____
_____

Brain:

___ Seizures ___ Loss of balance ___ Poor memory ___ Fainting ___ Vertigo
___ Tremors ___ Lack of coordination ___ Confusion ___ Loss of consciousness

Dizziness Y/N Acute/Chronic

___ w/fatigue ___ w/heavy head, fogginess ___ sudden onset ___ w/ nausea
___ w/standing from sitting/lying ___ feels like the room is spinning
Other information?

_____
_____
_____

Eyes:

___ Black under eyes ___ Needle-like pain ___ Blurred vision ___ Light sensitivity
___ Cloudy vision ___ Tearing ___ Swollen & red ___ Floaters/spots
___ Dry eyes ___ Redness ___ Itchy
Other information?

_____
_____
_____

Ears:

Tinnitus (ringing in ears) Y/N
Pitch: _____ (high, low, intermittent)
Onset: _____ (sudden, gradual)
Increases/Decreases with pressure or covering ear
Hearing loss Y/N
Onset: _____ (sudden, gradual)
___ Discharge ___ Dizziness ___ Frequent Earaches ___ Loss of equilibrium
Other information?

_____
_____
_____

Nose & Throat:

___ Allergies/Hay Fever ___ Chronic sinus congestion ___ Recurrent sore throat ___ Goiter
___ Decreased sense of smell ___ Chronic sinus infections ___ Dry throat
___ Sense of obstruction or binding in the throat
Phlegm color _____
Other information?

_____
_____
_____

Thorax/Chest/Lungs:

Heart:

___ Low blood pressure ___ High blood pressure ___ Tachycardia ___ Bradycardia

Heart murmur Y/N

Type & Quality: _____

Palpitations Y/N

Type & Quality: _____

Chest/ribs:

___ Chest pain ___ Chest distention ___ Costal pain

___ Chest tightness ___ Chest oppression ___ Epigastric pain

Breathing:

___ Difficulty inhaling ___ Wheezing ___ Childhood asthma ___ Difficulty exhaling

___ Asthma ___ Frequent colds ___ Shortness of breath (SOB) w/o exertion

___ SOB w/exertion

Cough:

___ Dry cough ___ Chronic cough ___ Unproductive cough ___ Coughing up blood

___ Productive cough

Phlegm: Y/N Phlegm color _____

Other information?

_____

_____

_____

Energy:

Time of day energy is lowest: _____ Level: 1-10 _____

Time of day energy is highest: _____ Level: 1-10 _____

Do you feel like you would like to sleep all day? Y/N

Do you take naps? Y/N if yes, how frequently? _____

Do you fatigue easily? Y/N

Other information?

_____

_____

_____

Sleep:

Average hrs per night: _____

Quality of sleep:

___ Difficulty falling asleep ___ Dream disturbed sleep ___ Wakes feeling not rested

___ Difficulty staying asleep ___ Sleepy after eating ___ Night sweats/Hot flashes

___ Waking early & can't go back to sleep; if yes, at what time: _____

Other information?

_____

Skin:

___ Eczema ___ Rashes ___ Dry skin ___ Bruises easily ___ Psoriasis

___ Acne ___ Itchy skin ___ Spider veins ___ Varicose veins

Other information regarding your skin?

_____

_____

Heat/Cold:

Fever/Chills:

___ Fever ___ Chills < Fever ___ Alternating chills & fever ___ Low-grade fever at night
___ Chills ___ Chills > Fever ___ Low-grade fever, constant

Hot/Cold

___ Aversion to cold ___ Cold hands ___ Patient feels cold (subjective)
___ Aversion to heat ___ Cold feet ___ Patient feels hot (subjective)

Over all would you say you run hot or cold? _____

Other information?

_____

_____

_____

Sweat:

___ Profuse sweating ___ Inability to sweat ___ Spontaneous sweat ___ Night sweats

Quality: _____ (warm/cold, sticky/watery)

Is there a particular time of day that you sweat more often?: _____

Area(s) of body:

_____

Other information?

_____

_____

_____

Appetite & Diet:

Appetite:

___ Excessive appetite ___ Always hungry ___ Prefer hot foods ___ Distention after eating
___ Poor appetite ___ No appetite ___ Prefer cold foods ___ Vomiting after eating

Taste in Mouth?

___ Bitter ___ Sweet ___ Sour ___ Salty ___ Burnt ___ Metallic

Digestion:

___ Nausea ___ Belching ___ Bloating ___ Gall stones
___ Vomiting ___ Hiccups ___ Abdominal pain ___ Acid reflux

Cravings:

_____

Thirst:

___ Excessive thirst ___ Thirst w/no desire to drink ___ Desire for cold drinks
___ Absence of thirst ___ Thirst w/sipping drinks ___ Desire for hot drinks

Other information regarding your appetite and diet?

_____

_____

_____

Bowel Movements & Urination:

Bowel Movements:

Tendency: _____ (constipation, diarrhea, loose stools)

Frequency: _____

Character:

_____

(i.e: dry, small (pebbles/bitty), thin, BM relieves pain, pain worse after BM, alternating constipation/diarrhea)

___ Floating stools ___ Bloody stools ___ Food in stools ___ Hemorrhoids

___ Black stools ___ Mucus in stools ___ Light colored stools ___ Rectal pain

___ Bowel movement feels incomplete ___ Need to wipe excessively

Urination:

Color: _____

Frequency:

_____

Character:

_____

Pain w/urination: Y/N Before /During/After

___ Incontinence/dribbling ___ Copious urination ___ Rough flow ___ Nocturia

___ Retention of urine ___ Scanty urination ___ Decreased flow

___ Kidney stones

Other information?

_____

_____

_____

Mood:

___ Anger/Irritability ___ Sadness ___ Worry/over-thinking ___ Panic attacks

___ Depression ___ Grief ___ Anxiety ___ Inappropriate laughter

___ Cries easily

What emotion do you find yourself dealing with most often? _____

What emotion do you find yourself experiencing when you are off or stressed?

_____

Other information (please list any significant emotional upsets/traumas - e.g. death of loved one, loss of relationship)?

_____

_____

_____

_____

***Pain*: (please rate on a scale for 1 - 10; 1 = no pain, 10 = most severe)**

___ Neck pain ___/10 ___ Shoulder pain ___/10 ___ Hip pain ___/10

___ Thoracic pain ___/10 ___ Elbow pain ___/10 ___ Knee pain ___/10

___ Lumbar pain ___/10 ___ Wrist pain ___/10 ___ Ankle pain ___/10

___ Sciatica ___/10 ___ Hand pain ___/10 ___ Foot pain ___/10

Quality of Pain and other information (specify location):

_____

_____

_____

_____

(Descriptions of Pain: Pulling, sharp, heavy, colicky, burning, cold, dull, achy, distended, hollow)

___ Numbness/tingling

Location(s): _____

___ Muscle spasms/twitching

Location(s): _____

___ Muscle weakness/atrophy

Location(s): _____

MEN'S HEALTH

Date of last prostate exam? _____

Date of last colorectal exam? _____

Sexual Function:

___ impotence ___ premature ejaculation ___ inability to maintain erection

___ night time emission ___ wet dreams ___ pain with ejaculation

___ Anxiety related to sex and/or intimacy

Are you satisfied with your job/career at this point in your life? Y/N If no, why not?

_____

How do you manage the stress in your life?

_____

Do you have any hobbies?

_____

_____

Other information?

_____

_____

_____

_____

WOMAN'S HEALTH

Pregnancy:

Are you currently pregnant? Yes/No

Are you currently trying to get Pregnant? Yes/No

Number of Pregnancies? _____

Number of Births? _____

Have you ever miscarried? Yes/No If yes how many times? _____

Have you ever received treatment for infertility? Yes/No If yes what type?

_____

Menstruation:

How old were you when you received your first menses? _____

[If you have stopped menstruating please answer the follow questions according to your past history]

Date of your most recent menses: _____

Do you have regular periods? Yes/No

What is the average length of your menstrual cycle? _____ days

For how many days do you typically bleed? _____ days

Do you experience any pain or cramping with your period? Yes/No If yes:

Where in your body to you feel the pain/cramping? _____

Please describe the pain/cramping (e.g. sharp, dull, debilitating, nauseating; does it refer?):

When does the pain/cramping start? _____ When does it stop? _____

Please describe what is typical for the period blood (e.g. dark, bright red, clots, watery, thin, brownish, mucous)?

Do you experience PMS? Yes/No If yes, please briefly describe your symptoms (e.g. fatigue, irritability, weepy):

Do you ever experience spotting? If yes when (e.g. before, during or after your period):

Do you ever experience ovulatory pain? Yes/No If yes, please describe:

Do you ever experience leukorrhea (discharge)? Yes/No If yes, please describe (e.g. the quality, odor, color):

Date of last gynecological exam: _____

Have you ever had an abnormal exam? Yes/No If yes, when and what were the results?

Currently taking birth control? Yes/No If yes, what type?

Name of birth control Rx (if applicable): _____

# of years taking birth control Rx _____

Do you ever experience pain with intercourse?

Menopause (if applicable):

Age of Menopause: _____

Did you experience or are you experiencing peri-menopausal symptoms? Yes/No

If yes please describe your experience (insomnia, hot flashes, emotional upset) :

Taking HRT ? Yes/No If yes, what type & brand of HRT:

Other:

Are you satisfied with your job/career at this point in your life? Y/N If no, why not?

How do you manage the stress in your life?

Do you have any hobbies?

Any other information about your health that you think is important for us to know?