Date: ______________________

Integrative Eastern and Western Health Questionnaire

Please Note: By filling out this form, you are consenting to the sharing of your health information between Ziji Kaufman (Aura Healer) and Rebecca (Licensed Acupuncturist and Oriental Medicine Practitioner) for their collaborative healing work on your behalf.
In all other respects, your information will be kept confidential.

To facilitate the process of Eastern and Western Medical diagnosis, it is important that the information you provide be as complete as possible.

FIRST NAME, LAST NAME INITIAL: ____________________________________

Age: _____ Gender (circle): M / F

Medication Allergies: ____
____
____

Food or Environmental Allergies: ____
____
____

Describe your allergic symptoms or signs: ____
____
____
____

Do you have any history of Seizures, or Fainting? ______________________________________

Do you have a pacemaker, or other type of electronic device implanted in your body? _____________

If yes, please describe location and reason ____

____

Please describe your symptoms or health issue(s) for which you initially sought out ZiJi's assistance.

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How long have you had this condition? _______________. The onset was: Sudden ____ / Gradual ____

Symptoms are relieved or improved by____.

____

____

Symptoms are worsened by____.

____

____

What medical diagnosis have you received for this condition? ____________________________________

____

____

What other treatments have you received for this condition? ____________________________________

____

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Can you relate the onset of your symptoms to any major event, or any change in lifestyle? (For example, a change in: diet, exercise, occupation, sleep, stress level, relationship, personal loss, etc.)

Describe: ____

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On the following drawings, shade in the areas where you feel should be addressed.

IF YOU HAVE PAIN, please check words that best describe your pain:

____Sharp ____Stabbing ____Dull ____Throbbing ____Diffuse ____Focused ____Aching

____Sore ____Burning ____Itching ____Shooting, nerve-like pain ____Tingling or numbness

____Intermittent (comes and goes) ____Continuous

____Location of pain moves from place to place, or is difficult to locate

____Radiating (starts in one area and spreads to another)

Please add other descriptive words, if the above do not describe your pain: ________________________

Is your pain accompanied by **weakness** or **loss of function**? Yes / No

Accompanied by **redness**, **swelling**, or other **change in appearance** of affected part? Yes / No

Please describe ____

Please mark on the scale of 1 to 10, the number that represents the **Severity of your pain**:

EXAMPLE	(Not painful at all) **1**____________________________7____________**10** (worst pain ever felt)

YOUR PAIN: (Not painful at all) **1**____**10** (worst pain ever felt)

Please list your CURRENT MEDICATIONS

Medication Name	Dosage	For What Condition?	How long have you been taking this medication?

List any Herbs or other Supplements you are taking:

Herb, Supplement or Vitamin	Dosage	For What Condition?	How long have you been taking this?

Please describe any CURRENT THERAPIES you are undergoing:

Have you ever had acupuncture in the past? Yes / No

If yes, did you have regular treatments for a period of time? Yes / No For how long ?___________.

What was your response? ____.

Have you ever taken Traditional Chinese Herbal Formulas? Yes / No

Have you ever taken recreational, or non-medical drugs? YES / NO

Have you ever taken hormones, either 'over the counter' or prescription? YES / NO

Women:

Are you currently pregnant? Yes / No

Are you presently trying to get pregnant? Yes / No

YOUR PAST MEDICAL HISTORY

Circle any **childhood illnesses** you have had:

Measles, mumps, rubella, whooping cough, chickenpox, rheumatic fever, scarlet fever, polio.

Other____

List any **surgeries,** or **hospitalizations**, and **dates** these occurred. ________________________________

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Health Maintenance: Yearly Physical ______ Visual Exams_____ Dental Exams______

If over 50, have you had a Colonoscopy? ____ Blood Pressure checked? _____ Recent Blood Tests?_____

Adult Illnesses or **Diagnoses**	**Check if YES**	**Age or date** of illness / diagnosis	Please circle the appropriate choice:
Heart Disease			On medication / Resolved / Neither
Elevated Cholesterol			On medication / Resolved / Neither
Hypertension			On medication / Resolved / Neither
Diabetes			On medication / Resolved / Neither
Thyroid disease			On medication / Resolved / Neither
Respiratory Illness			On medication / Resolved / Neither
GERD			On medication / Resolved / Neither
Colitis or IBS			On medication / Resolved / Neither
Hepatitis / Liver Disease			On medication / Resolved / Neither
Urinary tract infections			On medication / Resolved / Neither
Kidney disease			On medication / Resolved / Neither
Arthritis / Gout			On medication / Resolved / Neither
Osteoporosis			On medication / Resolved / Neither
Hernia			On medication / Resolved / Neither
Cancer			On treatment / Resolved / Neither
Autoimmune Disorder			On medication / Resolved / Neither

HIV / AIDS			On medication / Resolved / Neither
Neurological Disorder			On medication / Resolved / Neither
Headaches/ Migraines			On medication / Resolved / Neither
Mental/ Emotional			On medication / Resolved / Neither
Others not listed:			
			On medication / Resolved / Neither
			On medication / Resolved / Neither
			On medication / Resolved / Neither
			On medication / Resolved / Neither

If you answered YES to any of the above, please give **additional details**:

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YOUR FAMILY HISTORY – **Please indicate whether any family members have had any of the illnesses listed in the Past Medical History section, or others**. List or describe in the space provided.

Father	
Paternal GF	
Paternal GM	
Mother	
Maternal GF	
Maternal GM	
Aunts	
Uncles	
Siblings	
Children	

Traditional Chinese Medical diagnosis attempts to determine underlying patterns in your constitution and health condition. In order to identify these patterns, we need to ask questions that may seem 'unrelated' to your condition. However, your answers are very important to be able decide upon the proper treatment.

Please circle any symptoms you have experienced recently, to a significant degree, or frequently, over a longer time period, or both:

TEMPERATURE & THIRST

Feel cold often Feel hot/ warm often Hot flashes Heat intolerance Cold extremities

Sweating at night Excessive sweating Frequently thirsty

No thirst Desire for cold drinks Desire for warm drinks Thirsty, but can't drink much

ENERGY, SLEEP and EMOTIONS

Fatigue Tired in the morning Tired in the afternoon Tired after meals

Best energy in morning Best energy at night Excessive Energy Lack of motivation Indecisive

Insomnia: Difficulty falling asleep Frequent awakening Early am awakening

Irritable/ restless sleep Frequent, vivid dreams Nightmares Easily Angered

Impatient Unable to relax Depressed Hyperactive Anxious Perfectionist

Obsessive thinking Tendency to worry Sadness Unresolved grief Fears or phobias

HEAD, FACE & SENSES:

Dizziness Difficult concentration Poor memory Mental "fog"

Headaches or Migraines Describe:____

Blurry Vision See spots/floaters Painful/red eyes Dry Eyes Itchy or Watery eyes

Sinus congestion Sinus pain Allergies Runny nose Nose bleeds

Ear pain Ringing in ears Clogged/popping in ears Hearing loss

Dry mouth Cold sores Mouth Sores Bleeding gums Breath odor Facial Acne or Flushing

Dry throat Sore throat: Frequent/ Mild/ Severe Hoarseness Difficulty swallowing

SKIN, NAILS & HAIR:

Itching Rashes Oily skin Dry skin Other skin problem__________________

Brittle, thin nails Nail fungus Dry lusterless hair Hair thinning Premature Graying

CHEST & CARDIO

Frequent colds Chest congestion Dry cough Cough with phlegm (Color: ___________)

Shortness of breath on exertion Shortness of breath at rest Asthma

Chest pain Chest tightness Palpitations Pain in sides or ribs

ABDOMEN & DIGESTION

Reflux (GERD) Stomach pain Nausea Vomiting Belching Colic

Gas Bloating Constipation Diarrhea Painful bowel movements Hemorrhoids

DIET & HUNGER

Lack of appetite Frequent hunger Excessive appetite Hungry but can't eat

Eating disorder Food intolerances ____

Crave foods that are: Sweet Salty Sour Bitter Spicy Meaty Carbohydrates

URINATION

Difficult Frequent Urgent Painful Scanty Profuse

Incontinence or leaking Weak stream Strong odor

Urine Color: Clear/ pale Yellow Cloudy Dark Pink or with blood

Other: ____

MUSCLES, BONES & JOINTS:

Weakness Reduced muscle mass Decreased mobility Muscle stiffness, or spasm

Spinal problems Neck pain Osteoporosis Fractures Joint pain Joint swelling

Weak or sore back Weak or sore knees Hot, inflamed joints Tendon injuries

EXTREMITIES: Calf or foot cramps Numbness/ Tingling Bluish or white extremities

Swollen ankles Hot palms/soles Varicose veins Other ________________________

REPRODUCTIVE – WOMEN ONLY **(MEN, skip to bottom of page 10)**

Age of onset of menses: ___________.

How many: Pregnancies______, Births ______, Miscarriages or Therapeutic Abortions______.

Are you on birth control pills (BCP's)? YES / NO. If YES, what type and dosage? ____________________.

For how long?________________________.

Do you use another type of birth control? If so, what type?___________________________.

Are you post-menopausal? YES / NO.

Hormonal Replacement (HRT)? YES /NO. What type? ______________. For how long? ____________.

Do you have an annual gynecology exam and Pap screening done regularly? YES / NO

Any history of vaginal infections, STD's or other inflammatory condition?_____________.

Do you do Breast Self-Exams? Circle: Never Rarely Monthly Weekly

If you are age 40 or older, do you have annual or bi-annual screening mammograms? YES / NO

Ever had an abnormal result on a Mammogram? ________. On a Pap test? ________.

If you currently have periods, please answer the following questions regarding your menstrual pattern.

If you are postmenopausal, please answer the questions **regarding your menstrual pattern <u>in the past</u>**.

Average Cycle length (from **1st day** of period to **1st day** of next period): ________days.

Average days of flow:________ days.

I have or had (check all that apply):

Irregular periods Medium flow Light flow Heavy flow Painful periods Clots

PMS or Discomfort before period (describe): ____

Fatigue or other symptoms: During period __________________. After period ____________________

Spotting between periods Vaginal itching/burning Vaginal discharge (Color________________)

History of: uterine fibroids ovarian cysts endometriosis fertility problems STD PID

Other____

REPRODUCTIVE – MEN ONLY

Low Libido Decreased Sexual Function History of fertility problems

Prostate Problems Testicular Pain Inguinal Hernia

History of STD Genital Rash or other inflammation Other ___________________________

ALL PATIENTS:
If there is anything else that you wish to let us know about, ask us about, or to have addressed in your treatment, please include additional information or questions here:

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Thank you!