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ZEST
Acupuncture and Wellness

Consultation Form

Name:	
Address:	
DOB:	**Marital status:**
Email:	**Mobile/Tel:**
Occupation:	**What do you do repeatedly at work?**
GP Name and Surgery Address:	
Name and phone no. of your emergency contact person:	

Medications:

Supplements:

Main complaint:

When and how did this begin? What makes it worse? What makes it better?

What does this problem affect? (please circle all that apply):

- physical well-being: walking, standing, sitting, lying down, bending, exercise,
- sleep, rest, recreation,
- work, social life, family, sexual life,
- confidence, emotions, mental well-being

Which treatments did you try for this issue in the past? Mark with "+" or "-" if they helped or not.

Secondary complaints:

What are your health goals? What is your chosen outcome?

What obstacles could compromise your chosen outcome?

What is your commitment level to achieve the outcome? (1-10, 10=100%):

How long do you think it will take?

What do you do to relax? What are your passions / hobbies?

Family's medical history (please indicate all conditions that any of the family members had or have):

- heart disease, heart attack, stroke, arteriosclerosis
- high blood pressure, low blood pressure,
- arthritis, gout, diabetes,
- pneumonia, tuberculosis,
- jaundice, hepatitis, HIV/AIDS, cancer,
- hypo/hyperthyroid,
- epilepsy, seizures, multiple sclerosis,
- mental illness, mental breakdown

Surgeries or invasive procedures (please name):

Diet (please mark any that applies):

- strictly vegetarian, strictly vegan, mostly vegetarian
- low-fat, high fat,
- low carb, high carb,
- raw food diet,
- dieting (restricting calories), fasting
- gluten-free, dairy-free,
- other (please name):

Female concerns:

- Date of your last menstruation:
- Is your cycle regular? Y / N
- Average length of the cycle:
- Is your period painful? Y / N
- Do you take contraceptives? How many years? Y / N
- Number of pregnancies:
- Number of children:

SIGNS AND SYMPTOMS

Please circle all that apply now and underline all from the past. Or, use two different colors.

Mental / nervous system:

- phobias, nervousness,
- dyslexia, dyspraxia,
- can't say no, hard to relax,
- poor concentration,
- stuttering, confusion,
- depression,
- seizures, epilepsy,
- panic attacks, anxiety,
- restless, ADD, ADHD,
- bipolar disorder, OCD, PTSD,
- abuse survivor,
- other (please name):

Emotions:

- moody, easily irritated,
- angry, short temper, outbreaks of rage,
- indecisive,
- excessive worrying, over-thinking,
- melancholy, sadness, grief,
- cry easily,
- nervous giggling,
- fearful, low self-confidence,
- stressed, anxious,
- difficult to express emotions,
- other (please name):

Habits:

- smoking,
- alcohol,
- black tea, coffee,
- diet soft drinks, regular soft drinks,
- recreational drugs

Energy levels:

- tired in the morning,
- generally fatigued,
- tired in the afternoon,
- tired after meals,
- good, moderate, great

Circulatory system:

- chest pain or tightness,
- heart palpitations,
- heart attack, heart arrhythmia,
- congestive heart failure,
- stroke, arteriosclerosis,
- high cholesterol,
- high / low blood pressure,
- varicose veins, bruise easily,
- feeling hot, burning hands / feet,
- afternoon/evening fever, constant low-grade fever,
- blushing, hot flushes,
- feeling cold, cold hands, cold feet,
- anaemia,
- dizziness when standing up, fainting,
- numbness or tingling sensations,
- other (please name):

Respiratory system:

- difficulty inhaling,
- difficulty exhaling,
- **cough:** prolonged cough, dry cough, cough with phlegm, cough with blood,
- shortness of breath, asthma, wheezing,
- sinus problems,
- sleep apnea, snoring,
- bronchitis, tuberculosis, pneumonia,
- frequent colds / flus,
- frequent tonsillitis / sore throat, frequent strep throat,
- emphysema,whooping cough,
- other (please name):

Exercise:

- never or little,
- moderate,
- heavy

Digestive system:

- bloating, gas, belching,
- constipation, diarrhea, IBS,
- intestinal cramping, abdominal pain, frequent hiccups,
- smelly stools, blood in stools, mucous, in stools, undigested food in stools
- poor appetite, no appetite in the morning,,
- food allergies or intolerances,
- heartburn, acid reflux,
- nausea, vomiting,
- stomach or duodenal ulcers, gastritis,
- lack of stomach acid,
- frequent use of antibiotics, low microbiota in the gut,
- pancreatitis,
- fatty liver, liver cirrhosis, hepatitis,
- gallbladder disease, gallstones,
- haemorrhoids,
- other (please name):

Females ONLY:

- **menstruation:** excessive bleeding, very dark blood, clots, irregular periods, absent periods, very light bleeding, spotting between periods,
- **before periods:** abdominal cramps / pain, back pain, breast pain, irritable
- **after periods:** abdominal cramps / pain, back pain, breast pain, irritable
- low sex drive, high sex drive,
- vaginal discharge (yellow / white), vaginal itching, vaginal pain,
- PCOS, endometriosis, hysterectomy,
- infertility, pregnancy termination, miscarriage,
- C-section, perineal tear or cut,
- breast lump, breast pain,
- other (please name):

Immune system:

- frequent colds or nasal congestion,
- easily catching of viral diseases,
- chronic fatigue, fibromyalgia, lupus,
- rheumatism, arthritis,
- ulcerative colitis, Crohn disease,
- coeliac disease,
- hay fever,
- swollen glands/lymph nodes,
- measles, mumps, chicken pox,
- shingles, scarlet fever,
- multiple sclerosis,
- herpes, HIV/AIDS,
- other (please name):

Urinary system:

- urinary tract infections,
- incontinence, pain /difficulty when urinating, waking up at night to urinate,
- pale urine, dark yellow urine, cloudy urine, blood in urine ,
- kidney stones,
- other (please name):

Males ONLY:

- low sex drive, high sex drive,
- premature ejaculation, nocturnal emissions,
- enlarged prostrate,
- impotence, vasectomy,
- itching, testicle pain,
- other (please name):

General hormonal issues:

- diabetes, low blood sugar level,
- Hashimoto disease, hypothyroidism, hyperthyroidism,
- low cortisol, high cortisol,
- males: low / high testosterone,
- females: low/high estrogen,
- other (please name):

Eyes, Ears and Nose:

- **vision:** poor vision, astigmatism, blurred vision, poor night vision,
- **eyes**: dry eyes, itchy eyes, red eyes, light sensitivity, floating spots in vision, twitching eyelids, cataracts, glaucoma,
- **ears:** poor hearing, deafness, tinnitus (ringing in ear) - high pitch, tinnitus - low pitch, frequent ear infections, ear aches,
- **nose:** congested nose, runny nose - clear discharge, runny nose - yellow/ green phlegm, frequent sinus infections, polyps, post nasal drip, nose bleeds,
- other (please name):

Headaches / Dizziness:

- headaches, migraines,
- dizzy when standing,
- faint easily
- motion sickness,
- vertigo,
- other (please name):

Skin and hair:

- eczema, acne,
- dry skin, oily skin, itchy skin,
- psoriasis,
- warts, abscesses, rash,
- fungal infection, athlete's foot,
- nail infection,
- hair loss, premature greying,
- other (please name):

Body temperature regulation:

- feel warm,
- hot hands, hot feet,
- feel cold,
- cold hands, cold feet, cold nose
- low grade fever,
- hot flashes,
- flashed face or cheeks

Mouth and Throat:

- **mouth:** dry mouth / throat, metallic / bitter / sour / foul taste in mouth, bad breath,
- **teeth:** bad teeth, abscesses, bleeding gums, root canal treatment, crowns, bridges, false teeth, braces,
- mouth ulcers, tongue ulcers, salivary gland inflammation,
- cold sores,
- jaw joint pain, grinding teeth,
- other (please name):

Sleep:

- difficulty to fall asleep, waking up in the night, waking up early, light sleep,
- tired in the morning,
- restless legs,
- vivid dreams, nightmares, no dreams at all

Perspiration:

- little or none,
- sweaty palms, sweaty feet, sweaty, forehead,
- occurs without exertion,
- excessive,
- night sweats,

Appetite:

- poor, poor in the morning,
- irregular,
- hungry at night,
- excessive,
- food cravings,
- craving salt, sweet, fat, dairy,
- other (please name):

Weight:

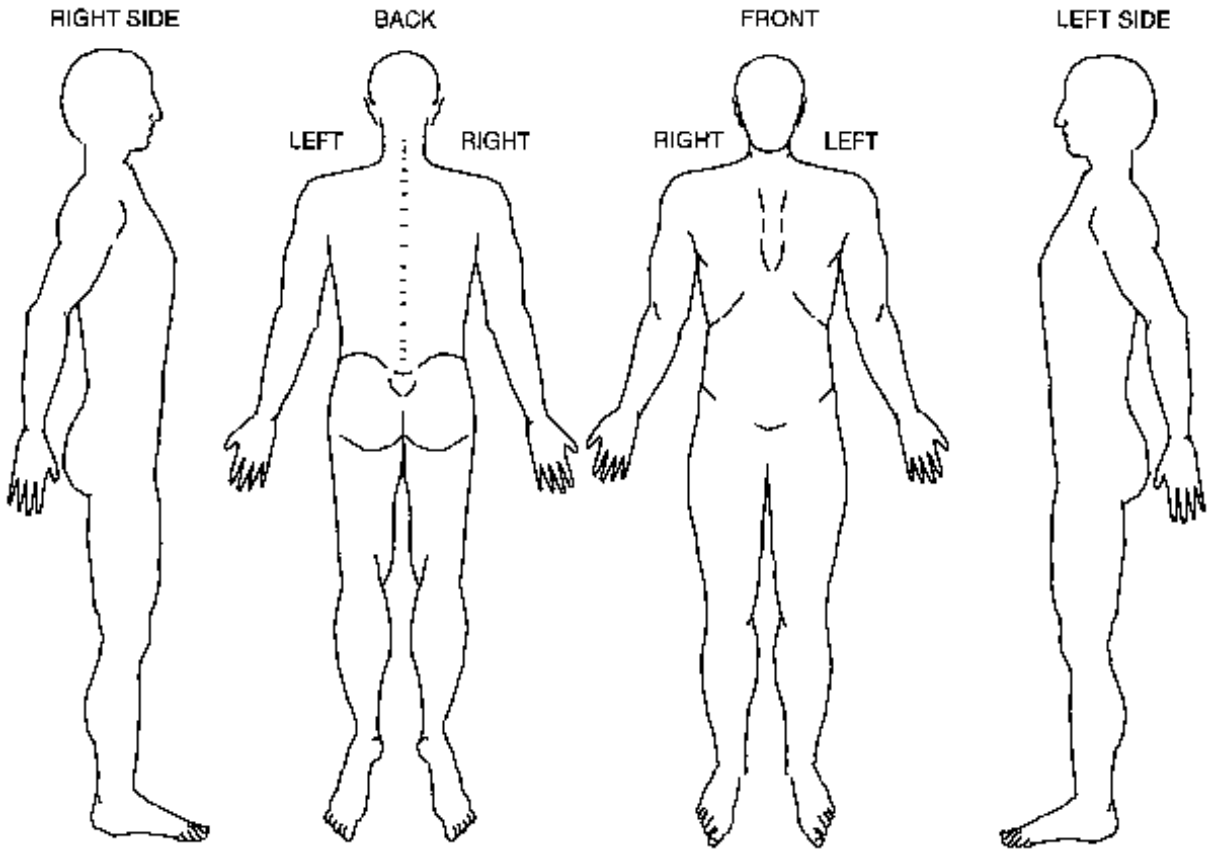
- unintended weight loss / gain,
- overweight,
- underweight

PAIN ASSESSMENT

Date:

Name: **DOB:**

Please shade the area(s) on the diagram where you feel pain, and draw lines for scar tissues.



Please indicate the severity of pain, close to the marked areas:

1-2 - light pain, 3-4 - tolerable pain, 5-6 - moderate pain, 7-8 - pain hinders most activities, 9 -10 - unbearable

What reduces your pain or makes it LIGHTER (circle all that apply):

- resting, moving around, lying down, sitting, standing
- hot shower, hot bath, heat pad,
- cold weather, hot weather, damp weather,
- massage

What makes your pain WORSE (circle all that apply):

- resting, moving around, lying down, sitting, standing
- driving, moving around,
- hot shower, hot bath, heat pad,
- cold weather, hot weather, damp weather,
- stress