



## COMMUNITY ACUPUNCTURE BERA

*Affiliated with WaysMeet Healing Arts Center, Inc.*

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### New Patient Health History

Please help me provide you with a complete evaluation by taking time before your first appointment to fill out this questionnaire carefully. All of your answers are absolutely confidential. If you are uncomfortable with any questions or unable to fill out this form, please let me know.

Today's date: \_\_\_/\_\_\_/\_\_\_

Name:

Date of Birth: \_\_\_/\_\_\_/\_\_\_

Primary care provider or specialist:

Referred by:

Main concern(s) you would like help with:

How long ago did this begin? Be specific:

To what extent does this problem interfere with you daily activities (such as work, sleep, recreation)?

Have you been given a diagnosis for this problem? If so, what is the diagnosis?

*(Continued on next page...)*

## MEDICAL HISTORY

Please list any significant illnesses, traumas and/or surgeries:

Please indicate (with a check) if you have been diagnosed with and/or are currently being treated by a physician for any of the following conditions:

- Hypertension (high blood pressure)
- Cardiac (heart) condition
- Acute, severe abdominal pain
- Undiagnosed neurological changes
- Unexplained weight loss or gain of more than 15% of body weight in last 3 months
- Suspected bone fracture or dislocation
- Suspected systemic infection
- Serious hemorrhagic (bleeding) disorder
- Acute respiratory distress without previous history
- Pregnancy
- Cancer

Have you ever had a seizure?

Are you diabetic?

Allergies (drugs, chemicals, foods):

Family Medical History (please circle):

Diabetes      Cancer      High blood pressure      Stroke  
Asthma      Allergies      Seizures (specify type):

Your occupation:

Work-related exposures or stressors (chemical, physical, psychological, etc.):

Do you have a regular exercise program? Please describe:

Are you or have you ever been on a restricted diet? If yes, please describe:

What do you eat on an average day:

(Continued on next page )

| Current medications/supplements: | Reason for taking: |
|----------------------------------|--------------------|
|                                  |                    |
|                                  |                    |
|                                  |                    |
|                                  |                    |
|                                  |                    |

**In the past 3 MONTHS have you experienced any of the following? (Please circle):**

- |                           |  |                            |
|---------------------------|--|----------------------------|
| Poor sleeping             | Night sweats                                 | Fevers                     |
| Chills                    | Cravings                                     | Sweat easily (when? _____) |
| Weight loss               | Weight gain                                  | Change in appetite         |
| Strong thirst             | Fatigue                                      | Bleed or bruise easily     |
| Peculiar tastes or smells | Sudden energy drop (what time of day? _____) |                            |

**Please circle any conditions you have experienced during the past 6 MONTHS:**

**SKIN & HAIR**

- |              |                           |          |              |
|--------------|---------------------------|----------|--------------|
| Rashes       | Ulcerations               | Hives    | Itching      |
| Eczema       | Pimples                   | Dandruff | Loss of hair |
| Recent moles | Other ( <i>specify</i> ): |          |              |

**H.E.E.N.T.**

- |               |                                |                |                           |
|---------------|--------------------------------|----------------|---------------------------|
| Dizziness     | Concussions                    | Migraines      | Glasses                   |
| Eyes strain   | Eye pain                       | Poor vision    | Color blindness           |
| Cataracts     | Blurry vision                  | Earaches       | Ringing in ears           |
| Poor hearing  | Spots in front of eyes         | Sinus problems | Nose bleeds               |
| Sore throats  | Mouth sores                    | Grinding teeth | Facial pain               |
| Reddened eyes | Headaches ( <i>describe</i> ): |                | Other ( <i>specify</i> ): |

**CARDIOVASCULAR**

- |                     |                           |                         |                     |
|---------------------|---------------------------|-------------------------|---------------------|
| High blood pressure | Low blood pressure        | Chest pain              | Irregular heartbeat |
| Swelling of hands   | Fainting                  | Cold hands and feet     | Phlebitis           |
| Swelling of feet    | Blood clots               | Difficulty in breathing |                     |
| Fevers:             | Other ( <i>specify</i> ): |                         |                     |

**RESPIRATORY**

- |                           |                |          |            |
|---------------------------|----------------|----------|------------|
| Cough                     | Coughing blood | Asthma   | Bronchitis |
| Pain with deep breath     | Phlegm         | Wheezing | Pneumonia  |
| Other ( <i>specify</i> ): |                |          |            |

**GASTROINTESTINAL**

- |                |              |                |                           |
|----------------|--------------|----------------|---------------------------|
| Nausea         | Vomiting     | Diarrhea       | Constipation              |
| Gas            | Belching     | Indigestion    | Poor appetite             |
| Abdominal pain | Loose stools | Cramps         | Bad breath                |
| Rectal pain    | Hemorrhoids  | Food allergies | Other ( <i>specify</i> ): |

(Continued on next page...)

**(Continued: Please circle any conditions you have experienced in the last 6 MONTHS)**

**GENITOURINARY**

Urgency to urinate      Unable to hold urine      Kidney stones      Pain with urination  
Blood in urine      Decreased urine flow      Impotence      Genital sores  
How many times per day do you urinate? \_\_\_\_\_      Other (*specify*):  
Do you wake to urinate? \_\_\_\_\_  
How many times/night? \_\_\_\_\_

**NEUROPSYCHOLOGICAL**

Depression      Poor memory      Anxiety      Easily irritated  
Nightmares      Restless sleep      Insomnia      Night sweats  
Seizures      Sensations/internal heat  
Loss of balance      Tremors /rigidity (*describe*):  
Area of numbness (*describe*):  
Lack of coordination (*describe*):

**MUSCULOSKELETAL**

Neck pain      Back pain      Knee pain      Shoulder/arm pain  
Hand/wrist pain      Foot/ankle pain      Joint pain      Hip pain  
Muscle pain      Muscle weakness      Other (*specify*):

**REPRODUCTIVE & GYNECOLOGIC**

Vaginal discharge      Vaginal pain/itching      Menstrual clots      Breast lumps  
Unusual periods      Spotting      Menstrual pain      Irregular periods  
Endometriosis

**Age of first menses:**

**Date of last Pap smear:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Date of last period:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**# Days periods last:** \_\_\_\_      **# Days between periods:** \_\_\_\_

**Age of menopause:**

**# Of pregnancies:** \_\_\_\_      **# Of live births:** \_\_\_\_      **# Of miscarriages:** \_\_\_\_

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**Please list any other issues you would like to discuss.**