

COMMUNITY ACUPUNCTURE BEREA

Affiliated with WaysMeet Healing Arts Center, Inc.

122 Main Street, Berea KY 40403

859-986-0098 (*answering machine*) | 419-710-9738 (*fax*)

CAB@CABerea.com (*email*)

www.CABerea.com

WHOLE-PERSON HEALTH HISTORY

Today's Date ___/___/___

If you are interested in an acupuncture evaluation, please complete this health history and bring, send or fax it to us. Your thoughtful and thorough responses to the questions on this form will make it possible to design an individualized treatment plan for you.

We suggest you keep a copy of this form for your own medical records. You will have an opportunity to ask questions and discuss concerns in more detail during your visit.

You will be contacted about your initial visit after we have received this completed history form.

Name _____ Date of birth ___/___/___ Age ___ Gender M F

Address _____

City _____ State _____ Zip _____

Phone (H) (____) _____ Phone (W) (____) _____ Phone (M) (____) _____

Email (H) _____ Email (W) _____

Why are you interested in acupuncture? Are you primarily concerned with improving your general health and well-being? Do you have particular health concerns you wish to address? Please describe.

How do YOU define health?

MEDICAL HISTORY

Primary Care Provider

Name _____ MD/DO/NP/PA

Address _____

City _____ State _____ Zip _____

Phone (____) _____ Fax (____) _____

Would you like to have a report sent to your primary care provider and/or other health practitioners, with a copy to you? Yes No

In the two sections below, please put a check in the column to the left of the name of any practitioner(s) to whom you wish reports sent. You may also need to complete a record release.

Please list all physicians and other conventional medical professionals whom you have seen in the past 2 years. Indicate which of these individuals are currently providing care for you.

| ✓ | Name MD/DO/ND/NP/PA | Street City, State, Zip Code Phone | Condition(s) being treated | Seeing currently? | |
|---|---------------------|--|----------------------------|-------------------|----|
| | | | | Yes | No |
| | | | | | |
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Please list all alternative or non-conventional health practitioners whom you have seen in the past 2 years (for example, chiropractors, acupuncturists, massage therapists, herbalists, etc.).

Indicate which of these individuals are currently providing care for you.

| ✓ | Name | Street City, State, Zip Code Phone | Type of therapy | Seeing currently? | |
|---|------|--|-----------------|-------------------|----|
| | | | | Yes | No |
| | | | | | |
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What complementary and alternative treatments have you used for your own self care and treatment of symptoms and conditions you have experienced?

Please check all you have used and circle the ones you are using now.

- | | |
|---|--|
| <input type="radio"/> Acupuncture | <input type="radio"/> Aromatherapy |
| <input type="radio"/> Art or creative therapy | <input type="radio"/> Ayurvedic medicine |
| <input type="radio"/> Biofeedback | <input type="radio"/> Chiropractic manipulation |
| <input type="radio"/> Counseling or psychotherapy | <input type="radio"/> Energy therapy (including Reiki) |
| <input type="radio"/> Exercise | <input type="radio"/> Folk remedies |
| <input type="radio"/> Herbal/botanical therapy | <input type="radio"/> Homeopathy |
| <input type="radio"/> Hypnosis | <input type="radio"/> Massage therapy |
| <input type="radio"/> Megavitamin therapy | <input type="radio"/> Movement, dance or music therapy |
| <input type="radio"/> Osteopathic manipulation | <input type="radio"/> Over-the-counter medications |
| <input type="radio"/> Physical therapy | <input type="radio"/> Prayer or meditation |
| <input type="radio"/> Prescription medications | <input type="radio"/> Qigong |
| <input type="radio"/> Reflexology | <input type="radio"/> Relaxation techniques |
| <input type="radio"/> Special diet | <input type="radio"/> Spiritual direction |
| <input type="radio"/> Spiritual healing (by others) | <input type="radio"/> Support groups |
| <input type="radio"/> Tai chi | <input type="radio"/> Vitamins or supplements` |
| <input type="radio"/> Writing or journaling | <input type="radio"/> Yoga |
| <input type="radio"/> Other _____ | <input type="radio"/> Other _____ |

When was the last time you had the following?

| | Date month/year | Never had/ don't know | Results/comments |
|--|--------------------|--------------------------|------------------|
| Comprehensive health examination | | | |
| Blood pressure check | | | |
| Blood sugar check | | | |
| Colonoscopy or sigmoidoscopy | | | |
| Cholesterol or lipid screening | | | |
| Dental exam/cleaning | | | |
| Eye/vision exam | | | |
| Tetanus shot | | | |
| Flu shot | | | |
| TB skin test | | | |
| HIV test | | | |
| Pap smear and/or pelvic exam (females) | | | |
| Mammogram (females) | | | |
| Bone mineral density test | | | |
| Testicular exam (males) | | | |
| Rectal exam to examine prostate (males) | | | |
| PSA (Prostate Specific Antigen) test (males) | | | |

PERSONAL AND FAMILY MEDICAL HISTORY

Have you or any of your relatives had the following?

| | Yes | No | Don't know | If yes, is it you (self) and/or a relative(s)? Which relative(s)? | Age at time of diagnosis | Comments |
|------------------------|-----|----|------------|---|--------------------------|----------|
| Heart disease | | | | | | |
| Stroke | | | | | | |
| High blood pressure | | | | | | |
| Diabetes | | | | | | |
| Thyroid disease | | | | | | |
| Breast cancer | | | | | | |
| Colon cancer | | | | | | |
| Other cancer(s) | | | | | | |
| Depression | | | | | | |
| Mental health disorder | | | | | | |
| Seizure disorder | | | | | | |
| Osteoporosis | | | | | | |
| Autoimmune disorder | | | | | | |
| Arthritis | | | | | | |
| Respiratory disorder | | | | | | |
| Other | | | | | | |

ALLERGIES

Are you allergic to anything (foods, drugs, latex, pollen)? Yes No
If yes, what are you allergic to and what happens when you take it or are exposed to it?

DIET

Height _____ Current weight _____ Weight one year ago _____

Are you on a special diet? Yes No If yes, please describe.

Are you presently trying to lose or gain weight? Yes No If so, how?

Are there foods you avoid for religious or health reasons? Yes No If yes, please describe.

On average, how many cups of caffeinated beverages do you drink in a day? _____

What kind(s) of beverage? _____

EDUCATION

What is the highest grade in school that you have completed? Please circle.

- | | |
|--------------------|--|
| Grade school | College (degree and subject) _____ |
| Middle school | Graduate school (degree and subject) _____ |
| High school or GED | Other _____ |

Can you read and/or write? Yes No If no, who is helping you complete this form? _____

What kind of work do you do? If retired, what have you done in the past? _____

EXERCISE AND SAFETY

Do you exercise? Yes No If yes, what do you do? _____

How often? _____ For how long? _____

Do you wear seatbelts? Always Often Only on long trips Never

If you ride a bicycle or motorcycle, do you wear a helmet? Always Often Only on long trips Never

EXPOSURES AND TRAVEL

Are you currently, or have you been in the past, exposed to any dangerous work conditions (such as chemicals, dust, radiation, machines)? Yes No If yes, please describe.

Have you ever lived outside the United States for more than three months? Yes No
If yes, where? _____ When? _____

Have you traveled outside the United States in the past year? Yes No
If yes, where? _____ When? _____

HOME LIFE

Who, besides you, lives in your home (including pets)? _____

What is your current status? Please circle one. Single Married Divorced Widowed

Do you have a partner or significant other? Yes No If yes, for how long? _____

Are there others for whom you are primary caretaker (children, parents, others)? Yes No
If yes, who? _____

RELIGION/SPIRITUALITY

Does religious faith or spirituality play an important part in your life? Yes No

Do you consider your religious faith or spiritual beliefs important to your health? Yes No

Do you belong to a church, synagogue, or spiritual community? Yes No If yes, what type?

What are your sources of hope, strength, and comfort in difficult times?

How do you deal with stress (for instance, prayer, meditation, exercise, friends)?

Do you have a living will or advance directives? Yes No Don't know

SEXUAL HEALTH

Are you currently sexually active? Yes No

Do you consider yourself at risk for sexually-transmitted diseases? Yes No

Do you have any questions or concerns about your sexual activity or function? Yes No

TOBACCO/ALCOHOL/DRUGS

Do you currently use tobacco? Yes No If yes, what type? _____

How much? _____ For how long? _____

If yes, have you ever tried to quit using tobacco? Yes No If yes, how? _____

Have you used tobacco in the past? Yes No For how long? _____ When did you quit? _____

Have you ever been exposed to second-hand smoke for extended periods of time? Yes No

If yes, please explain.

Do you drink alcohol? Yes No If yes, what type? _____ How often? _____

How much? _____ Alone or with others? _____

Has your alcohol use ever presented a problem for you or for others? Yes No If yes, please explain.

Has anyone else's alcohol use ever had an adverse effect on you? Yes No If yes, please explain.

Have you ever used drugs not prescribed for you or had a problem with drug abuse? Yes No

If yes, please explain.

TRAUMA/CRISIS

Have there been any recent changes or crises in your life or in your family? Yes No If yes, please describe.

Have you ever experienced a traumatic event, been seriously injured, or felt your life was threatened? Yes No

If yes, please describe.

FINANCIAL MATTERS

Do you have health insurance? Yes No If yes, what kind? _____

Have you checked to see whether your insurance will provide reimbursement for the cost of complementary treatments? Yes No Does it cover acupuncture provided by a physician? Yes No

Do you have a flexible spending account or health savings account (HSA)? Yes No

If yes, have you confirmed that you may apply the cost of acupuncture? Yes No

Please think for a moment about what you hope to achieve from your evaluation and treatment. List the concerns you would like to address in the order of their importance to you.

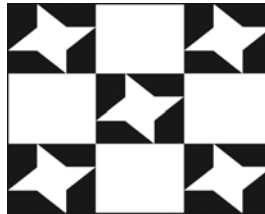
1. _____
2. _____
3. _____
4. _____
5. _____

How did you learn about the availability of acupuncture in Berea? Please check and/or describe.

- Physician or health care provider Who? _____
- Internet directory or search Which website? _____
- Email message
- Friend or family member
- Poster or brochure Where? _____
- Sign
- Don't remember
- Other Please describe. _____

Your signature: _____ Date: ___ / ___ /200__

If you cannot keep your initial appointment, please be in touch by phone or email at least 48 hours before your scheduled visit. By doing this, you may avoid being charged for your missed appointment and someone on the waiting list may be able to receive care.



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