PATIENT HEALTH HISTORY

Welcome to Bergen Acupuncture and Integrative Medicine, LLC. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential in conformation with our Privacy Policy. If you have questions, please ask us.

Name:_____Age:_____DOB: _____ Social Security Number:_____
Address: _____ City _____State_____ Zip_____
Phone 1: _____ H □ W □ C □ Phone 2:_____ H □ W □ C □ E-mail: _____
Marital Status: S M D W Place of Birth:_____ Occupation: _____
Emergency Contact:_____ Relationship_____ Phn No:_____
Current Physician:_____ Phn No: _____ Referred by:_____
Have you tried acupuncture before? _____If so, when and for what reason? _____

MAIN HEALTH PROBLEM

What is the main health problem for which you are seeking treatment? _____
_____
To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?_____
_____
When did you first notice any symptoms? _____
Have you been given a diagnosis for the problem by a physician or chiropractor? _____
If so, what is it? _____
What kinds of treatment or therapy have you tried? _____

PAST MEDICAL HISTORY (check all which apply)

□ Allergies □ Cancer □ Diabetes □ Hepatitis
□ High Blood Pressure □ Heart Disease □ Seizures □ Surgeries
□ Venereal Disease □ Thyroid Disease □ Vaccinations □ Childhood Illnesses
□ Accidents □ Other (please specify) _____

MEDICATIONS (**List all**, including supplements, with doses and frequency)

_____
_____

FAMILY MEDICAL HISTORY (check all which apply and specify which blood relative)

□ Allergies □ Cancer □ Seizures □ Diabetes
□ Heart disease □ Stroke □ Asthma □ High blood pressure
□ Other (please specify) _____

LIFESTYLE (please indicate the use and frequency of the following)

□ Coffee □ Black Tea □ Tobacco □ Alcohol
□ Caffeinated Beverages □ Recreational Drug
□ Exercise (please specify type) _____
Please describe your average daily diet: _____
_____

OCCUPATION

Occupational stress factors (physical, psychological, chemical): _____

GENERAL

□ Changes in appetite □ Weight change □ Disturbed sleep □ Night sweats
□ Fever □ Chills □ Localized weakness □ Sweating easily
□ Sudden energy drop □ Cravings □ Tremors (time of day?) _____ □ Strong thirst
□ Bleeding or bruising easily □Poor balance
Other unusual or abnormal conditions you have noticed in your general sense of health: _____

_____

SKIN AND HAIR

□ Itching □ Dandruff □ Ulcerations □ Redness
□ Eczema □ Psoriasis □ Hair Loss □ Hives
□ Pimples □ Other (please specify) _____

HEAD, EYES, EARS, NOSE, THROAT

□ Dizziness □ Eye Pain □ Blurred Vision □ Floaters
□ Spots in Eyes □ Night Blindness □ Ringing in Ears □ Poor Hearing
□ Headaches (Where? When?)_____ □ Migraines
□ Recurrent Sore Throats □ Sores on Lips/Tongue □ Heat on the face
□ Dry Mouth/Throat □ Bleeding Gums □ Nosebleeds □ Sinus Problems
□ Facial Pain □ Jaw Clicking □ Toothaches □ Teeth Grinding
□ Earaches □ Other (please specify) _____

CARDIOVASCULAR

□ Chest Pain □ Low Blood Pressure □ High Blood Pressure
□ Irregular Heart Beat □ Difficulty Breathing □ Cold Hands/Feet
□ Swelling of Hands/Feet □ Palpitations □ Blood Clots
□ Fainting □ Other (please specify) _____

RESPIRATORY

□ Nasal Congestion □ Cough □ Coughing Phlegm □ Coughing Blood
□ Asthma □ Shortness of Breath □ Bronchitis □ Pneumonia
□ Pain with deep breath □ Difficulty breathing when lying down □ Other (please specify)_____

GASTROINTESTINAL

□ Nausea □ Constipation/Difficult Bowel Movement □ Diarrhea
□ Vomiting □ Abdominal Pain/Cramps □ Indigestion
□ Gas/Bloating □ Belching □ Heartburn/Reflux
□ Lack of Appetite □ Excessive Appetite □ Bad Breath
□ Rectal Pain □ Black Stools □ Blood in Stool □ Hemorrhoids
□ Chronic Laxative Use □ Other (please specify) _____
Do you feel thirsty? □no □yes I prefer □ cold □ warm drinks.
Do you prefer foods that are □ sweet □ salty □ sour □ bitter □ spicy?

GENITO-URINARY

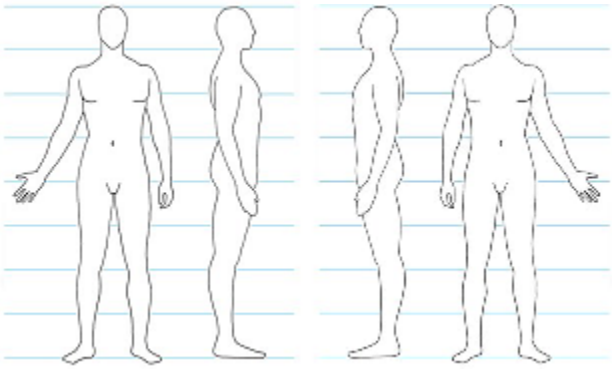
□ Pain on Urination □ Frequent Urination □ Blood in Urine □Dark Urine
□ Cloudy Urine □ Urgency to Urinate □ Unable to Hold Urine □Kidney Stones
□ Decrease in Urine Flow □ Impotence □ Waking at Night to Urinate
□ Other (please specify) _____

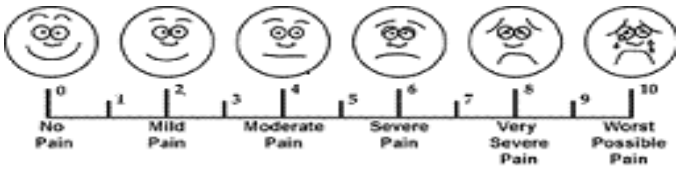
REPRODUCTIVE/GYNECOLOGICAL

Age of 1st Period _____ Age at menopause _____ # Pregnancies _____
Live Births_____ # Premature Births _____ # Miscarriages/Abortions _____
days between periods _____ # days of flow _____ Color of blood _____ □ Clots (Color _____)
□ Painful Menses □ Premenstrual Symptoms □ Irregular Menses
□ Strong Menstrual Odor □ Vaginal Discharge □ Vaginal Odor □ Vaginal Dryness
□Fibroids □ Breast Lumps/Swellings □ Endometriosis
□ Ovarian Cysts □ Sexually Transmitted Disease □ Urinary Tract Infection
□ Hot Flashes □ Decreased Sex Drive □ Positive Mammogram/Pap Smear
□ Other (please specify) _____

MUSCULO-SKELETAL

Please indicate area and level of pain





☐ Neck Pain ☐ Back Pain ☐ Knee Pain ☐ Muscle Pain

☐ Foot/Ankle Pain ☐ Shoulder Pain ☐ Hip Pain ☐ Sciatica

☐ Hand/Wrist Pain ☐ Muscle Weakness

☐ Other Joint/Bone Problems (please specify) _____

Does the pain move to other areas? _____

Does the pain get better with (check all that apply) ☐ heat ☐ cold ☐ pressure ☐ massage ☐ movement

NEURO-PSYCHOLOGICAL

☐ Seizures ☐ Dizziness ☐ Loss of Balance ☐ Areas of Numbness

☐ Lack of Coordination ☐ Poor Memory ☐ Depression ☐ Anxiety

☐ Irritable ☐ Easily Stressed ☐ Treated for Emotional Problems

☐ Other (please specify) ___ _____

I attest that the information I have documented on this form is accurate. I am also aware that I should consult with a licensed physician about my health issues.

_____ _____

Patient Signature Date

Authorization for Release of Information: (please initial)

_____ In an effort to properly manage and coordinate my individual treatment with my medical providers, I authorize this office to obtain/release healthcare information from/to _____ Address: _____ Phn:_____ for the above conditions. This authorization is voluntary and may be revoked at any time by notifying this office in writing. My health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164).

Provider Notes:

BP: _____

P: Ht:_____ Lu: _____ T: Body: _____

Lv: _____ Sp: _____ Coating: _____

Kd: _____ Kd: _____ Color: _____

Palpation: _____Observation:_____

Other: