Katherine Kuhn, RAc New Patient Information

Adult Personal History (Initial visit)

Name: _____ Birth Date: _____ Today's Date:_____

Address: _____

Home phone: _____ Work phone: _____ Cell phone:_____

Occupation: _____ Email: _____

Marital status: ❑married ❑single ❑divorced ❑ widowed ❑ domestic partner

Emergency Contact Name: _____ Phone: _____

Education/highest degree completed: _____

List Primary Care Physician: _____

List any Specialty Physicians: _____

List any Alternative or Complementary Care Providers: _____

List any **Allergies** (medications &/or environmental): _____

List any **Medications** you use (prescription &/or over-the-counter): _____

_____

_____

_____

_____

Do you:

Yes

- ❑ Exercise on regular basis
- ❑ Consume/ Eat a special diet _____
- ❑ Avoid certain foods. If so, please list: _____
- ❑ Do/Did you ever use tobacco products? If so packs per day _____ Number of years _____
- ❑ Drink alcohol. If so, how many drinks in a week? _____ per week
- ❑ Use 'street drugs' such as marijuana, cocaine, heroin? _____
- ❑ Use prescription narcotic pain pills? _____

***Continued on reverse side**

Past Medical History

Are your parents still living? Mother: ❑ yes ❑ no Father: ❑ yes ❑ no
If not, age & cause of death: Mother: _____ Father: _____

Past Medical History- Current, Past and/or Family History of:
If you were adopted, please complete the family history portion as completely as you can.

(check ONLY if applies)

	You	Family Member		You	Family Member
Alcoholism	❑	❑ Who? _____	Osteoporosis	❑	❑ Who? _____
Anemia	❑	❑ Who? _____	Skin Cancer	❑	❑ Who? _____
Arthritis	❑	❑ Who? _____	Stroke	❑	❑ Who? _____
Asthma	❑	❑ Who? _____	Thyroid Disease	❑	❑ Who? _____
Breast Cancer	❑	❑ Who? _____	HIV Positive	❑	
Cancer: _____	❑	❑ Who? _____	Polio or Meningitis	❑	
IBS	❑	❑ Who? _____	Rheumatic Fever	❑	
Colon Cancer	❑	❑ Who? _____	Sexually Transmitted Disease	❑	
Depression	❑	❑ Who? _____	Migraine Headaches	❑	
Diabetes	❑	❑ Who? _____	Stomach Ulcers	❑	
Epilepsy	❑	❑ Who? _____	Gout	❑	
			Hemorrhoids	❑	
			Hepatitis/Liver disease	❑	
Heart disease	❑	❑ Who? _____	Chicken Pox	❑	
High Blood Pressure	❑	❑ Who? _____	Eating Disorder	❑	
High Cholesterol	❑	❑ Who? _____	Frequent infections/boils	❑	
Kidney Disease	❑	❑ Who? _____			
Lung Disease	❑	❑ Who? _____			
Mental Illness	❑	❑ Who? _____			
Obesity	❑	❑ Who? _____			

Other serious disease or illness or injury:_____

_____

Do you have concerns regarding you health or safety due to the work you do? _____

_____

Do you have concerns regarding you health or safety because of where you live (house, region)?

_____

Do you have any known limitations? _____

Prior Worker's Compensation Claims (Brief details) _____

_____

Surgeries & Hospitalizations

Tonsillectomy Date_____ Hysterectomy Date _____ Concussion_____

Appendectomy Date _____ Vasectomy Date _____

Gallbladder Date _____ Tubal Ligation Date _____

Other operations:
Type _____ Date _____
Type_____ Date _____
Type _____ Date _____

Type_____ Date _____
Type _____ Date _____

Any complications from surgery? ❑ yes ❑ no If yes, explain _____

_____

Ever had a blood transfusion? ❑ yes ❑ no If yes, date and reason _____

_____

Please List reasons for all other hospitalizations &/or Emergency Department visits:

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

WOMEN ONLY – Menstrual History

Age at first period: _____ Age at menopause, if appropriate: _____

Are your periods regular? ❑ yes ❑ no If no, please explain _____

How many days do you bleed? _____ How often do they come? _____

Do you have any bleeding between periods? ❑ yes ❑ no If yes, please explain _____

_____

Do you have to miss work or school due to painful periods? ❑ yes ❑ no

If you use birth control what method? _____

How many pregnancies have you had? _____ How many live children born? _____

Any miscarriages or abortions? _____ How many cesarean-sections? _____

Any complications w/ pregnancy? _____

Do you perform monthly self-breast exams? ❑ yes ❑ no Have you noticed any lumps? ❑ yes ❑ no

***Continued on reverse side**

Please check **ONLY** those that apply

Head, Eyes, Ears, Nose & Throat

- ❑ Frequent or severe headaches
- ❑ Dizziness or fainting spells
- ❑ Blurred or double vision
- ❑ Change in hearing or ringing in your ears
- ❑ Earaches
- ❑ Frequent or severe sinus infections
- ❑ Nose bleeds
- ❑ Frequent or severe sore throat
- ❑ Recurrent sores in your mouth
- ❑ Bleeding gums
- ❑ Persistent hoarse voice

Heart/Lungs

- ❑ Chest pain or pressure
- ❑ Thumping or racing in your heart
- ❑ Chronic cough
- ❑ Cough with sputum or blood
- ❑ Shortness of breath with very mild exercise
- ❑ Difficulty breathing when lying down flat
- ❑ Swelling in your hands or feet
- ❑ Cramps in your legs while walking or at night

Hormones

- ❑ Hot flashes
- ❑ Increased in frequency of urination
- ❑ Change in thirst
- ❑ Change in skin or hair texture
- ❑ Feeling either hot or cold when others are comfortable

Urinary/Genitals

- ❑ Pain with urination
- ❑ Dark, tea colored urine
- ❑ Blood in your urine
- ❑ Loss of urine when coughing/sneezing
- ❑ Difficulty in starting urination/weak stream
- ❑ Males- Check for lumps in testicles
- ❑ Males- Difficulty maintaining an erection
- ❑ Discharge from your penis or vagina

Are you sexually active? ❑ yes ❑ no

- ❑ Satisfied with your sex life
- ❑ Pain with intercourse

- ❑ Have female partners
- ❑ Have male partners

Method of birth control _____

- ❑ Use condoms

- ❑ None of the above

Intestinal

- ❑ Cough when laying down
- ❑ Poor appetite
- ❑ Frequent episodes of nausea or vomiting
- ❑ Yellow skin or eyes
- ❑ Difficulty swallowing
- ❑ Frequent indigestion or heartburn
- ❑ Change in size, shape or texture of your stools
- ❑ Change in regularity of your bowel movements
- ❑ Vomiting blood or what looked like 'coffee grounds'
- ❑ Black tarry stools
- ❑ Rectal bleeding/blood in your stools

Muscle/Bones/Joints

- ❑ Any problems with exercise
- ❑ Frequent or severe backaches
- ❑ Stiff or swollen joints
- ❑ Muscle spasms
- ❑ Redness or heat in joints

Neurological

- ❑ Bad or frequent headaches
- ❑ Seizures or feeling 'out of control'
- ❑ Change in strength of arms or legs
- ❑ Change in speech
- ❑ Trembling of hands or feet
- ❑ Difficulty walking or keeping balance
- ❑ Loss or change in sensation

Other

- ❑ Skin changes- rash, moles, lesions
- ❑ Currently or in last year seen a counselor
- ❑ Tearfulness
- ❑ Feel irritated or worried
- ❑ Feel sad or down
- ❑ Trouble falling or staying asleep
- ❑ Thoughts of suicide or harming yourself
- ❑ Tiredness without apparent reason
- ❑ Unexpected change in weight
- ❑ Night sweats
- ❑ Significant concerns about work or family
- ❑ Ever been hit, hurt, frightened or neglected in your home
- ❑ Ever felt guilty about your drinking
- ❑ Ever felt the need to cut down on your drinking
- ❑ Ever felt annoyed by criticism of your drinking

- ❑ None of the above