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INTEGRATIVE MEDICINE INTAKE QUESTIONNAIRE

Current Date _____/_____/_____

Name _____
Date of Birth _____/_____/_____

Welcome to the integrative medicine consult clinic! This questionnaire has been designed so that we can both review your past medical history and other factors in your life that affect your health. The questionnaire makes it possible for us to be more thorough because we want to help you. Some of this information is already in your medical record, but we are going to ask you to repeat it here to be sure we are getting your complete history. Some questions are very personal - if you do not wish to answer these, please skip over them. You may use an additional sheet of paper if needed. All information collected will be kept strictly confidential. Thank you for your patience.

General Health:.....❒ excellent ❒ good ❒ fair ❒ poor

Magic Wand: Imagine you had a magic wand and could change three things about yourself and your life. What would they be?

1. _____
2. _____
3. _____

What is the reason for your visit?_____

Please describe the onset of this illness – when was the last time you felt completely well, what was going on in your life at the time it started:

_____

_____

_____

What treatments have you tried so far for your situation?_____

_____

_____

Is there anything in particular that you are hoping for from this consultation? Any specific questions? _____

_____

_____

Past Medical Illnesses:

- ❒ accidents, broken bones, other serious injury
- ❒ anemia (low blood count) or bleeding problems
- ❒ lung problems: pneumonia, emphysema, etc.
- ❒ heart problems, high blood pressure, etc.
- ❒ gland problems: diabetes, thyroid trouble, etc.
- ❒ gastrointestinal problems: ulcers, diarrhea, etc.
- ❒ high cholesterol
- ❒ psychiatric problems: depression, hallucinations, etc.
- ❒ allergies (asthma,eczema,hayfever)
- ❒ cancer, including skin
- ❒ liver or kidney problems
- ❒ pain: low back pain, headaches, etc.
- ❒ skin disease
- ❒ tuberculosis (or positive skin test)
- ❒ sexually transmitted diseases
- ❒ neurologic: seizures, MS, pinched nerve, etc.

OTHER (and dates and details on items checked above): _____

_____

_____

What other diagnoses have you been told you have?

_____ _____

_____ _____

_____ _____

Past Surgeries (include approximate date and type of procedure):_____

_____

_____

Hospitalizations (include approximate date, where and why):_____

_____

_____

Trauma (Any serious injuries/accidents, head injuries, loss of consciousness? Please explain):_____

_____

_____

Current medications (**include prescription drugs, over-the-counter medicines, sleeping pills, aspirin, laxatives, vitamins, herbs, or supplements etc.** and indicate dose and frequency):

Name	Dosage	How many times a day

PLEASE BRING ALL YOUR BOTTLES TO YOUR VISIT!

Allergies:

Do you have drug allergies?....❒ Yes ❒ No What? (list medication and reaction):

Drug	Adverse Drug Reaction

Do you have any food allergies?....❒ Yes ❒ No What? (list food and reaction):

Food	Reaction

Family History:

Are you adopted? .....❒ yes ❒ no

Please list medical history for:

Relationship	Name(s)	Age	Living/Deceased	Medical Problems
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____

Has anyone in your family had trouble with the following:
(Include mother(M), father(F), sister(S), brother(B), grandmother (GM), grandfather(GF), aunts(A), uncles(U).)

	YES	NO	UNSURE	WHO?
Alcoholism or drug abuse	_____	_____	_____	_____
Blood clots in legs or chest	_____	_____	_____	_____
Depression or mental illness	_____	_____	_____	_____
Suicide or Suicide Attempts	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
			(What organ(s)?)	_____
Heart attack before age 50	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____
High cholesterol	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____
Mental Retardation	_____	_____	_____	_____
Liver Disease	_____	_____	_____	_____
Bleeding Problems	_____	_____	_____	_____
Congenital Abnormalities	_____	_____	_____	_____

Other: _____ _____ _____ _____

Social History:

Are you currently married or in a commited relationship?.....❒ yes ❒ no

If so, who is your "significant other"? _____

If not, have you ever been married or in a committed relationship? .....❒ yes ❒ no

Military Service: ❒ yes ❒ no……..When?_____Where?_____

Circle one: Right-handed or Left-handed

Are you sexually active at this time?.....❒ yes ❒ no

Do you want to discuss safe sex, AIDs, or other sexual issues with the doctor?.....❒ yes ❒ no

Travel: Have you ever been in (or are you from):.....❒ a foreign country? ❒ another region of the United States?

Where were you born? _____

Where did you grow up? _____

How long have you lived at your current residence?_____

Education completed:.....❒ grade school ❒ high school ❒ trade school ❒ college ❒ other

Are you currently a student, and if so, where?_____

❒ Full-time ❒ Part-time_____

Occupation:_____

Currently ❒ employed or ❒ unemployed (*last worked* _____*)* or ❒ Retired?

Work hours per week _____

❒ Night Shift

Health concerns regarding your work: ❒ stress ❒ repetitive motions ❒ heavy lifting ❒ dust, or loud noises ❒ verbal harrassment or abuse ❒ other _____

Living situation:

What is your current living situation?_____

Who do you live with?_____

Do you have a Stove/place to cook where you live?.....❒ yes ❒ no

Do you feel your current housing is adequate?.....❒ yes ❒ no

Do you feel your home is safe?.....❒ yes ❒ no

Are there any firearms in your house?.....❒ yes ❒ no

If so, are they stored safely?.....❒ yes ❒ no

Do you handle or have exposure to chemicals? *(examples: glue, bleach, ammonia, pesticides, fertilizers, Cleaning solvents, etc.)*

At home?.....❒ yes ❒ no At work?.....❒ yes ❒ no With hobbies?.....❒ yes ❒ no

Do you have any children? .....❒ yes ❒ no

If so, please list: Full Name Age Full Name Age

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Do any of your children or your partner's children live with someone else? .....❒ yes ❒ no

If Yes, please explain: _____

_____

Safety: Do you ever ride in a car without wearing a seat belt? .....❒ yes ❒ no

Exercise: Do you exercise?.....❒ less than once a week? ❒ 1 - 3 times per week? ❒ more than 3 times per week?

What kind of exercise? _____ For how long? _____

Hobbies, other activities (church groups, sports, musical instruments, etc.):

_____

_____

Habits (please indicate if you have ever used and how much you use now):

Caffeine: coffee, tea, soda .....❒ yes ❒ no

How many servings per day of: coffee? _____ tea? _____ soda? _____

Tobacco:

Are you exposed to second hand smoke at home?.....❒ yes ❒ no

Do you smoke cigarettes now? .....❒ yes ❒ no

in the past? .....❒ yes ❒ no

If so, how many packs per day?_____ For how many years?_____ How old were you when you started?_____

If you currently smoke, have you ever quit before? .....❒ yes ❒ no

If yes, for how long? _____

Do you use chewing tobacco, snuff, cigars, a pipe, or other forms of tobacco?.....❒ yes ❒ no

Would you like help in quitting tobacco now? .....❒ yes ❒ no

Alcohol: How often do you drink an alcoholic beverage(beer, wine, liquor, mixed drinks, etc.)?

Drinks per day_____ Drinks per week_____ How many drinks does it take to make you feel "high"?_____

If you drink, have you ever felt the need to cut down your drinking?.....❒ yes ❒ no

felt annoyed by criticism of your drinking? .....❒ yes ❒ no

had guilty feelings about your drinking? .....❒ yes ❒ no

taken a morning "eye-opener"? .....❒ yes ❒ no

When was your last drink? _____

Other: Do you use any other recreational **drugs**? .....❒ yes ❒ no

❒ marijuana ❒ crack/cocaine ❒ Crank/methamphetamines

❒ heroin ❒ downers

❒ other _____

_____

If you use drugs and/or alcohol, are you interested in quitting? .....❒ yes ❒ no

Have you tried to quit? .....❒ yes ❒ no

Comments:_____

Have you ever used drugs through a needle? ..... ❒ yes ❒ no

Are you concerned about the drinking/drug use of any other members of your family? ..... ❒ yes ❒ no

Diet:

Do you follow a special diet(vegetarian, low salt, low fat, etc)? ..... ❒ yes ❒ no

Please describe:_____

How many times a week do you eat red meat? _____

How many servings of fruit or vegetables do you eat every day ? _____

Has your weight ever been a problem for you? ..... ❒ yes ❒ no

What methods have you used to lose/gain weight? _____

_____

How much water do you drink in a day?_____

Please list what you ate and drank yesterday, with approximate amounts:

Breakfast	Lunch	Dinner	Snacks

Stress:

Do you feel stress is a problem in your life ..... ❒ yes ❒ no

Are you currently providing care for a disabled or elderly family member? ..... ❒ yes ❒ no

Do you have concerns about your children or your relationship with them? ..... ❒ yes ❒ no

Are you afraid of your own temper or that of anyone else in your family? ..... ❒ yes ❒ no

Do you have problems with getting angry frequently or at little things? ..... ❒ yes ❒ no

Do you sometimes feel out of control? ..... ❒ yes ❒ no

Do you sometimes feel you are no good or you can't do anything right? ..... ❒ yes ❒ no

Have you ever thought about or tried to commit suicide ..... ❒ yes ❒ no

Does someone you live with have serious health or emotional problems? ..... ❒ yes ❒ no

Have you or anyone on your block been shot or mugged in the last year? ..... ❒ yes ❒ no

Is there any history of violence in your family? ..... ❒ yes ❒ no

Has anyone close to you ever physically hit you or hurt you? ..... ❒ yes ❒ no

Do you feel unsafe in your current relationship?. ..... ❒ yes ❒ no

Is there a partner from a previous relationship who is making you feel unsafe now? ..... ❒ yes ❒ no

How do you deal with conflict in your family?_____

_____

Traumatic Events: (please include any emotional, physical, sexual trauma; or if you have witnessed any traumatic events that have affected you---ex. car accident, war, etc.)

Childhood Trauma: _____

_____

_____

_____

Adult Trauma:_____

_____
_____
_____

Social Support:

Do you frequently feel isolated or alone?.....❒ yes ❒ no
Do you feel people take advantage of you or try to control you?.....❒ yes ❒ no
Are you dissatisfied with the way your family communicates or expresses affection?.....❒ yes ❒ no
Who provides you with emotional support(family, close friend, religious advisor, other)?_____
_____

Spiritual Life:

Is there a particular spiritual practice or belief system that is meaningful to you?.....❒ yes ❒ no
Name or Description (optional): _____
Do you practice this singly and/or with a group?.....❒ alone ❒ yes, with a group
Would you be willing to have us contact your spiritual advisor and/or other support people in the event you became very ill?.....❒ yes ❒ no
Contact person: _____ Phone: (_____) _____ - _____
Did you/your family follow a particular spiritual practice when you were a child?.....❒ yes ❒ no
If so, name or description: _____

Pets: Do you have any pets? .....❒ yes ❒ no

Name	Species	Name	Species
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other providers involved in your care: Do you see other health care providers other than your primary doctor here *(such as a therapist, other physicians, chiropractors, accupuncturists, naturopaths, herbalists, etc.)* on a regular basis? ...❒ yes ❒ no

Who do you see?	Name	Profession
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Would you like your integrative provider here to consult with/coordinate your care with your other provider(s)? ❒ yes ❒ no

Review of Symptoms(check off symptoms within the last 3 months)

GENERAL
Difficulty falling asleep Yes No_____
Difficulty staying asleep Yes No_____
Number of hours of sleep per night:
_____
Number of hours in bed per night:
_____
Are you a habitual snorer? Yes No_____
Do you feel refreshed
when you wake up? Yes No_____
Do you have excessive
daytime sleepiness? Yes No_____
Are you frequently ill? Yes No_____
Are you a nervous person? Yes No_____
What forms of exercise do you do? Please list._____

NEUROLOGICAL
Frequent or severe headaches Yes No_____
Fainting, unconsciousness Yes No_____
Uncoordination Yes No_____
Seizures Yes No_____
Dizziness Yes No_____
Weakness Yes No_____
Numbness Yes No_____
Depression Yes No_____
Paralysis Yes No_____

SKIN
Unusual pigmentation Yes No_____
Itching Yes No_____
Bleeding Yes No_____
Loss of hair Yes No_____
Lumps or changing moles Yes No_____

EYES
Color blindness Yes No_____
Double vision Yes No_____
Change in vision lately Yes No_____
Pain in eyes Yes No_____
Blurred vision Yes No_____
Do you wear glasses? Yes No_____
Do you wear contacts? Yes No_____
Do you have glaucoma? Yes No_____
When were your eyes last checked?_____
By whom?_____

EARS
Hard of hearing Yes No_____
Ringing in ears Yes No_____
Ear infection or discharge Yes No_____
Macular Degeneration Yes No_____

NOSE
Runny nose Yes No_____
Sneezing Yes No_____
Bleeding Yes No_____
Polyps Yes No_____

MOUTH
Sore Yes No_____
Dentures Yes No_____
When were your teeth last checked?_____
When were your teeth last cleaned?_____

GASTROINTESTINAL
What is the most you ever weighed?_____
What was your weight last year?_____
What is your weight now?_____
Have you lost weight recently? Yes No_____
Loss of appetite? Yes No_____
How long?_____
Difficulty Swallowing Yes No_____
Stomach Pain Yes No_____
Heartburn Yes No_____
Ulcers Yes No_____
Vomiting Yes No_____
Vomiting up blood Yes No_____
Gallbladder disease Yes No_____
Hepatitis Yes No_____
Jaundice Yes No_____
Constipation Yes No_____
Diarrhea Yes No_____
Bowel movements turn white Yes No_____
Bowel movements turn black Yes No_____
Do you take an Iron supplement Yes No_____
Blood in bowel movement Yes No_____
Change in bowel habits Yes No_____
Hemorrhoids Yes No_____
Rectal problem Yes No_____
Have you had intestinal x-rays Yes No_____
If so, when?_____
Hernias Yes No_____

LUNGS
Asthma/wheeze Yes No_____
Bronchitis Yes No_____
Chronic obstructive Yes No_____
Pulmonary disease Yes No_____
Emphysema Yes No_____
Hoarse voice Yes No_____
Cough Yes No_____
How many times per day?_____
Productive? Yes No_____
Color_____ Amount per day_____
Ever coughed up blood Yes No_____
Shortness of breath? Yes No_____
Lying down Yes No_____
Sitting Yes No_____
Standing Yes No_____
Walking Yes No_____
How many blocks can you walk
without stopping on level ground?_____

How many stairs can you climb?_____

HEART

Chest pain: Rest/exertion Yes No_____
Palpitations (pounding of chest) Yes No_____
Irregular heart beat Yes No_____
Ankles swollen Yes No_____
Heart problem or heart attack Yes No_____
Heart murmur Yes No_____
Wake up short of breath Yes No_____
How many pillows do you sleep on? 1 2 3 4
Leg cramps when walking Yes No_____

GENITOURINARY

How many times do you urinate in the daytime?_____
How many times do you urinate in the nighttime?_____
Pain when urinating Yes No_____
Passed blood in urine Yes No_____
Change in urine color Yes No_____
Urine or bladder infection Yes No_____
Kidney stones Yes No_____
Year:_____
Trouble starting urine Yes No_____
Do you lose control of bladder Yes No_____
Prostate trouble Yes No_____
Last time prostate checked:_____

GYNECOLOGICAL

Pain or lumps in breasts Yes No_____
Discharge from breasts Yes No_____
Do you examine yourself regularly? Yes No_____

MENSTRUAL HISTORY:

Aqe at onset:_____
Aqe of menopause:_____
Regular or irregular cycle _____days
Duration of flow:_____days
Flow: heavy / medium / light
Last period: _____(date)
Recent spotting? Yes No_____
Hot flashes? Yes No_____
Vaginal dryness Yes No_____
Mood Changes Yes No_____
Vaginal discharge/color? Yes No_____
Last pap smear:_____
Pregnancies: Number of pregnancies:_____
Any complications_____
Number of miscarriages:_____
Weight of heaviest babv:_____

BIRTH CONTROL

Pills Yes No How long_____
IUD Yes No How long_____
Other Yes No How long_____

SEXUAL PROBLEMS

Lack of interest in sex Yes No_____
Problems with erection Yes No_____
Pain with sex Yes No_____
Lack of climax Yes No_____
Loss of lubrication Yes No_____

BONES AND JOINTS

Are joints painful or swollen Yes No_____
Muscle cramps Yes No_____
Arthritis Yes No_____
Gout Yes No_____
Osteoporosis Yes No_____

Are there other issues that you would like to discuss with your provider? Please describe: _____

_____

_____

_____

_____

_____

_____

_____

_____