



## 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 committed 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

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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:

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**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

<u>Name</u>	<u>Species</u>	<u>Name</u>	<u>Species</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**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 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:**

Age at onset: \_\_\_\_\_

Age 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 baby: \_\_\_\_\_

**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: \_\_\_\_\_

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