



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 within the constraints of a brief clinic visit. It is long and detailed! 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

What is the reason for the visit: _____

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. _____

Past Medical Illnesses:

- | | |
|---|--|
| <input type="checkbox"/> accidents, <input type="checkbox"/> broken bones, <input type="checkbox"/> other serious injury | <input type="checkbox"/> allergies <input type="checkbox"/> asthma <input type="checkbox"/> eczema <input type="checkbox"/> hayfever |
| <input type="checkbox"/> anemia (low blood count) <input type="checkbox"/> bleeding problems | <input type="checkbox"/> cancer <input type="checkbox"/> including skin |
| <input type="checkbox"/> lung problems: <input type="checkbox"/> pneumonia, <input type="checkbox"/> emphysema, <input type="checkbox"/> other _____ | <input type="checkbox"/> liver <input type="checkbox"/> kidney problems |
| <input type="checkbox"/> heart problems <input type="checkbox"/> high blood pressure <input type="checkbox"/> other _____ | <input type="checkbox"/> pain: <input type="checkbox"/> low back pain <input type="checkbox"/> headaches <input type="checkbox"/> other |
| <input type="checkbox"/> gland problems: <input type="checkbox"/> diabetes <input type="checkbox"/> thyroid trouble | <input type="checkbox"/> skin disease |
| <input type="checkbox"/> gastrointestinal problems: <input type="checkbox"/> ulcers, <input type="checkbox"/> diarrhea <input type="checkbox"/> other _____ | <input type="checkbox"/> tuberculosis <input type="checkbox"/> positive skin test |
| <input type="checkbox"/> high cholesterol | <input type="checkbox"/> sexually transmitted diseases |
| <input type="checkbox"/> mental problems: <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> other _____ | <input type="checkbox"/> neurologic <input type="checkbox"/> seizures <input type="checkbox"/> MS <input type="checkbox"/> pinched nerve |
- OTHER** (and dates and details on items checked above): _____
- _____
- _____

Past Surgery (include approximate date and type of procedure):

Date	Type of procedure

Allergies:

Do you have drug/food allergies/intolerance?.... Yes No (list medication/food and reaction)

Current medications (include prescription drugs, over-the-counter medicines, vitamins, supplements or attach list):

Medication	Dosage	Frequency	Reason

Family History:

Are you adopted? yes no

Please list medical history for:

Relationship	Name(s)	Age	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
Mother			<input type="checkbox"/> Living <input type="checkbox"/> Deceased
Father			<input type="checkbox"/> Living <input type="checkbox"/> Deceased
Brother/s			<input type="checkbox"/> Living <input type="checkbox"/> Deceased
Sister/s			<input type="checkbox"/> Living <input type="checkbox"/> Deceased

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				
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:

Place of Birth: Where were you born? _____ Where did you grow up? _____

What is your current marital status? Single Married Divorced Other: _____

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

Do you have any children?..... yes no _____Son(s) _____Daughter(s)

Right handed Left handed

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

Occupation: _____ employed unemployed retired _____

Do you feel stressed at work? yes no if yes _____

Exercise: Do you exercise?.....No 1 - 3 times per week? more than 3 times per week?

What kind of exercise? _____ For how long? _____

Spiritual Life:

Is there a particular spiritual practice or belief system that is meaningful to you?..... yes no

Name or Description (optional): _____

Daily Nutrition

1. On average, how many times do you eat fast food in a **week**?

• Never •1 •2 •3 •4 •5 •6+

2. How often do you drink or eat any dairy product in a **week** i.e milk, cheese, yogurt?

• Never •1 •2 •3 •4 •5 •6+

3. How often do you eat meat in a **week** i.e. beef, pork, chicken, fish ?

• Never •1 •2 •3 •4 •5 •6+

4. How often do you eat grain in a **week** i.e. bread, rice, pasta, crackers, cereal?

• Never •1 •2 •3 •4 •5 •6+

5. Do you eat organic ? • Yes or •No

How many times in a **week**? •1 •2 •3 •4 •5 •6+

6. Do you drink caffeinated beverage? • Yes or •No

How many cups per **day** of: Coffee _____ Tea _____ Soda _____

7. How many sports drinks, flavored water, juice per **day** ?

• Never •1 •2 •3 •4 •5 •6+

8. How many servings of fruits and vegetables do you eat in a **day**?

• Never •1 •2 •3 •4 •5 •6+

9. How many times do you treat yourself in a **week** with candy or sweets?

• Never •1 •2 •3 •4 •5 •6+

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

Social Support:

How do you deal with conflict in your family? _____

Who provides you with emotional support(family, close friend, religious advisor, other)? _____

Other providers involved in your care: Do you see other health care providers other than your primary doctor (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

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

PROCEDURES

DATE

Last Physical Exam	
Lab Results/Blood Work	
Urine Test	
MRI	
CT Scan	
EKG	
EEG	
X-ray	
Ultrasound	
Colonoscopy	

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

GENERAL	YES	NO	NOSE	YES	NO
Difficulty falling asleep			Runny nose		
Difficulty staying asleep			Bleeding		
Number of hours of sleep per night			Polyps		
Are you a nervous person ?			Sneezing		
Are you frequently ill?			MOUTH		
NEUROLOGICAL			Sore		
Frequent or severe headaches			When were your teeth last checked?		
Fainting, unconsciousness			When were your teeth last cleaned?		
Problems with coordination			EARS		
Seizures			Hard of hearing		
Dizziness			Ringing in ears		
Weakness			Ear infection or discharge		
Numbness					
Depression			GASTROINTESTINAL		
Paralysis			What is the most you ever weighed?		
SKIN			What was your weight last year?		
Unusual pigmentation			What is your weight now?		
Itching			Have you lost weight recently?		
Bleeding			Loss of appetite?		
Loss of hair			Difficulty Swallowing		
Lumps or changing moles			Stomach Pain		
EYES			Heartburn		
Color blindness			Ulcers		
Double vision			Vomiting		
Pain in eyes			Vomiting up blood		
Blurred vision			Gallbladder disease		
Do you wear glasses or contacts?			Hepatitis		
Do you have glaucoma?			Jaundice		
When were your eyes last checked?			Constipation		
Macular Degeneration			Diarrhea		

GASTROINTESTINAL		YES	NO	GENITOURINARY		YES	NO
Do you take an Iron supplement				How many times do you urinate in the daytime?			
Blood in bowel movement				How many times do you urinate in the nighttime?			
Hemorrhoids				Pain when urinating			
Rectal problem				Passed blood in urine			
Hernias				Change in urine color			
				Urine or bladder infection			
LUNGS				Kidney stones... Year: _____			
Asthma/wheeze				Trouble starting urine			
Bronchitis				Do you lose control of bladder			
Chronic Obstructive Pulmonary disease				Prostate trouble. Last time check: _____			
Emphysema				GYNECOLOGICAL			
Hoarse voice				Pain or lumps in breasts			
Cough				Discharge from breasts			
Ever coughed up blood				Do you examine yourself regularly?			
Shortness of breath?				MENSTRUAL HISTORY			
Lying down				Age at onset: _____			
Sitting				Age of menopause _____			
Standing				Regular or Irregular Cycle _____ days			
Walking				Duration of flow: _____ days			
HEART				Flow: <input type="checkbox"/> heavy, <input type="checkbox"/> medium or <input type="checkbox"/> light			
Chest pain: Rest/exertion				Last Period: _____			
Palpitations (pounding of chest)				Recent spotting ?			
Irregular heart beat				Hot flashes?			
Ankles swollen				Vaginal dryness			
Heart problem or heart attack				Vaginal discharge/color?			
Heart murmur				Last pap smear: _____			
				Number of pregnancies: _____			
BONES AND JOINTS							
Are joints painful or swollen							
Muscle cramps							
Arthritis							
Gout							