

Center For Integrative Therapy - Intake Form

Please complete this form to the best of your ability. All questions are optional.
Skip the question that do not apply to you

Name _____

DOB: _____ Sex _____

Primary Care Provider _____ Date _____

Email _____

Phone: Home: _____ Cell: _____ work: _____

What is your opinion of your overall level of health? Excellent _____ Good _____ Fair _____ Poor _____

In your opinion(not necessarily your health care providers), what are your most important health care problems. Please list your concerns in their order of importance to you:

1) _____

2) _____

3) _____

4) _____

5) _____

What do you think might have caused your chief complaint and what other, possibly unrelated events, occurred around the time your chief complaint began? _____

PLEASE DESCRIBE YOUR GOALS AND EXPECTATIONS FOR YOUR APPOINTMENT AT THE INTEGRATIVE MEDICINE CLINIC:

If you are experiencing pain now or having on-going pain please fill out the following section.

How long have you had it? _____

Mark an X on the line where you feel your pain is currently:

No Pain

worst pain

0 1 2 3 4 5 6 7 8 9 10

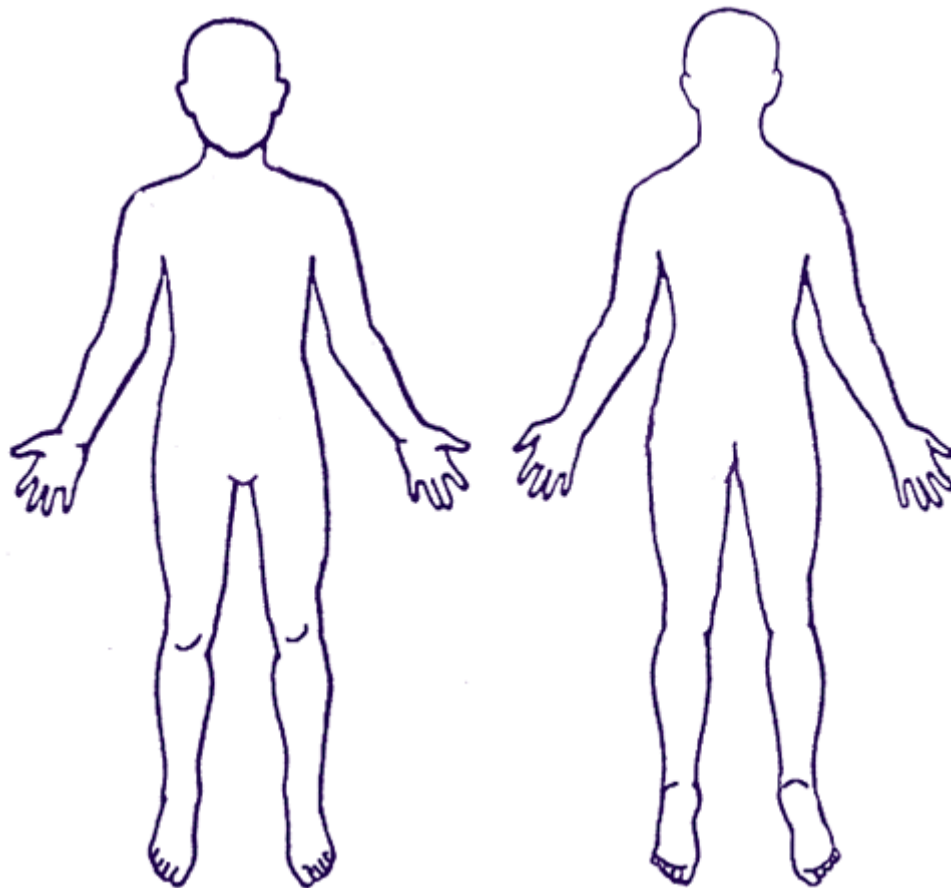
Quality _____

Radiation _____

What makes it worse? _____

What makes it better? _____

Location _____



How does this pain affect your daily activities:

Please describe any accidents you have had and the time frame:

Current or Past medical conditions/illness:

Surgeries with dates:

Menstrual History(women) with age of onset of menstruation and date of last menstrual period:

Psychiatric Hospitalization:

Family History of health problems(parents, grandparents, siblings, children, spouse if applicable):

Please list year of most recent:

Colonoscopy

Stool test

Mammogram (female)

Pap smear (female)

Flu Shot

Pneumonia shot

Current prescription medications:

Please list any natural health product; herbs, supplements, vitamins you are currently taking:

Product: _____ Brand: _____ Dose: _____ How often: _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Allergy/intolerance to medications or substances:

Please list names of **complementary and Alternative therapy or practitioner** you have tried:

Personal and Social History:

Living situation/Housemates: _____

Pets: _____

Occupation(current/past): _____

Education: _____

Do you currently do any regular **exercise or yoga or meditation practice**, please list when you started and how often you do it _____

What kind of activity makes you feel **spiritual**? _____

What are your **hobbies**? _____

Please list the type of **volunteer work** that you are doing currently or have done in the past:

Are you sexually active? If yes, then how many sexual partners have you had in last one year? _____

What is your sexual orientation? Homosexual _____ Heterosexual _____

Married _____ Single _____ Divorced _____ Children _____

Please indicate your stress level in the past one month by circling the appropriate spot:

*No
stress*

*completely
stressed out*

0 1 2 3 4 5 6 7 8 9 10

What do you do for **relaxation or coping**? _____

Please rate your emotional state in the past one month by circling the appropriate spot:

Sad

Happy

0 1 2 3 4 5 6 7 8 9 10

You consider yourself to be more of an optimist or a pessimist? Please circle the appropriate spot:

Pessimist

Optimist

0 1 2 3 4 5 6 7 8 9 10

Where would you put your **current energy level** at? Please circle the appropriate spot:

*No
energy*

*Highest
energy*

0 1 2 3 4 5 6 7 8 9 10

What time of the day you have **lowest energy level**? _____

Which time of the day you have **highest energy level**? _____

How is your **sleep pattern**? Poor _____ Good _____ Excellent _____

Please describe your **mood** _____

Please describe your **childhood** _____

How was your **health as a child**? Good _____ Fair _____ Poor _____

Please list any major emotional, verbal or sexual trauma that you have experienced as a child or adult:

Diet and nutrition History:

Please list food consumed in last twenty four hour including beverages, condiments and snack;

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Types of food you crave or eat a lot: _____

Types of food you dislike or eat rarely: _____

How many cups (8 oz) of water do you drink on a typical day? _____

How many servings of fruits you eat on a typical day? _____

One serving of fruit (USDA dietary guidelines) is;

Fruits

- 1/2 cup fruit or 1 medium piece of fruit or
- 1/2 grapefruit or 1/4 small cantaloupe or
- 1/4 cup dried fruit or 1/2 cup berries or
- a dozen grapes or 3/4 cup fruit juice (100% juice)

How many servings of vegetables you eat on a typical day? _____

one serving of vegetable (USDA dietary guidelines) is;

Vegetables

- 1/2 cup chopped vegetables or 1 cup raw leafy vegetables(a small salad) or
- 6-8 carrot sticks (33 long) or 1 medium potato or
- 1/2 cup cooked or canned dry beans or peas or
- 3/4 cup vegetable juice

What type of cooking oil do you cook with? _____

What type of spread you add to your food? _____

Do you drink **coffee**? If yes, how much per day? _____

Do you drink **soda**? If yes, how much per day? _____

Do you now or have ever used **tobacco**? _____ If yes, how much per week? _____

Do you now or have ever used **alcohol**? _____ If yes, how much per week? _____

Do you now or have ever used **marijuana**? _____ If yes, how much per week? _____

Do you now or have ever used any **recreational drugs**? _____ If yes, which ones and how much?

Highest weight ever: _____ **Desired weight** _____

Current symptoms (circle the one you are having problem with, explain if necessary):

Allergy _____

Arthritis(which joint) _____

Asthma _____

Bitter Taste in mouth _____

Blurry Vision _____

Breathing problem _____

Brittle nails _____

Bruising _____

Bursitis _____

Cancer/tumor _____

Chest pain/tightness _____

Cough(dry or productive) _____

Diabetes _____

Difficulty Concentrating _____

Digestive Problems _____

Ear ringing _____

Easily angered _____

Emphysema _____

Fatigue _____

Frequent colds/flu _____

- Hearing problem _____
- Heart condition(type) _____
- Hemorrhoids _____
- High blood pressure _____
- Hot flashes _____
- Infections(where?) _____
- Irregular heart beat/ rapid heart beat _____
- Low blood pressure _____
- Nightmares _____
- Night sweats _____
- Numbness/tingling(where?) _____
- Menstrual /gynecological symptoms _____
- Poor appetite _____
- Poor memory _____
- Red/dry eyes _____
- Sciatica _____
- Seizures/convulsions _____
- Skin condition/rash(where?) _____
- Stroke _____
- Trouble sleeping _____
- Urinary problems _____
- Varicose Veins _____
- Weak immune system _____

Is there any other information that you would like to share with us? _____

Thank you for taking time to complete this form. This information will be very helpful in your health assessment and treatment.

We look forward to your visit and help you in healing and wellness.

