INTEGRATIVE MEDICINE CONSULTATION INTAKE FORM

The following questions are designed to help us understand your overall health and well-being, address your health concerns, and identify your health goals. Since the integrative approach seeks to know the whole person, you will find questions to ascertain your physical, emotional, mental, and spiritual health in addition to information about your medical condition/s. If you cannot respond to some questions at this time, but would like to discuss this at future visits, or if you have other information to share that hasn't been covered, please indicate so at the "Other Information" section at the end of the form.
In order to optimize your clinic visit time with us, we request that you complete this form and **bring it** with you to your appointment. The information you provide and those gathered from your clinic visit will be used to create your integrative health care plan.

We look forward to working with you to achieve your optimal health and well-being!

GENERAL INFORMATION

Name: _____ DOB: _____

Primary Care Physician: _____

Complementary and alternative medicine (CAM) providers: _____

_____

Other healthcare providers you regularly see (please list):_____

_____

Please list the health concerns you'd like to be addressed at this visit. Begin with the most important one first. _____

_____

Does anyone else close to you have any concerns about your health other than what you have listed?

☐Yes ☐No

If yes, please provide more information: _____

_____

What would you like to get out of today's visit? _____

_____

Please list three health goals you'd like to achieve within the next 12 months:

1. _____
2. _____
3. _____

MEDICAL HISTORY

Medical Diagnosis	Onset (beginning date)	Treatment received or receiving

Injuries, Surgeries, Hospitalizations, etc.	Onset (beginning date)	Treatment received or receiving

Please list all prescription medications that you are currently taking

Name of Medication	Dosage	Reason for taking	Frequency

Please list over the counter medications, supplements, herbs, and/or homeopathic remedies that you are currently taking

Name of Medication	Dosage	Reason for taking	Frequency

Please list treatments, medications, supplements, and/or herbs you've used in the past that have not worked

Name of Treatment/Medication	Schedule of treatment/Dosage	Duration of treatment/use	Date treatment/medication discontinued

ALLERGIES/ SENSITIVITIES

Medications	Supplements/Herbs	Food	Environment (grasses, pollen, animal dander, etc.)

FAMILY HISTORY – Please list any health problems with your

Mother	Father	Sister/s	Brother/s	Grandparents	Other

REVIEW OF SYSTEMS

General

☐Yes ☐No - Difficulty Sleeping ☐Yes ☐No - Low energy ☐Yes ☐No - Hyperactivity

☐Yes ☐No - Restlessness ☐Yes ☐No - Feel too hot or too cold

☐Yes ☐No - Excessive weight loss/gain

If you marked yes to any of the above please describe: _____

_____

Cardiovascular (Heart)

☐Yes ☐No - Chest Pain ☐Yes ☐No - High blood pressure ☐Yes ☐No - Fainting

☐Yes ☐No - Irregular heartbeats ☐Yes ☐No - Rapid or pounding heartbeats

If you marked yes to any of the above please describe: _____

_____

Pulmonary (Lungs)

☐Yes ☐No – Shortness of breath ☐Yes ☐No – Chest Congestion ☐Yes ☐No – Wheezing

If you marked yes to any of the above please describe: _____

_____

Neurological

☐Yes ☐No – Headaches ☐Yes ☐No - Numbness ☐Yes ☐No - Dizziness

☐Yes ☐No - Weakness ☐Yes ☐No – Difficulty Walking ☐Yes ☐No - Falling

☐Yes ☐No – Poor Memory ☐Yes ☐No – Poor Coordination

☐Yes ☐No – Speech difficulties ☐Yes ☐No – Difficulty concentrating/focus

If you marked yes to any of the above please describe: _____

_____

Stomach and Intestines

☐Yes ☐No – Heartburn ☐Yes ☐No - Constipation ☐Yes ☐No - Diarrhea

☐Yes ☐No - Cramping ☐Yes ☐No – Blood in stool ☐Yes ☐No - Gas

☐Yes ☐No – Bloating ☐Yes ☐No – Nausea ☐Yes ☐No – Vomiting

☐Yes ☐No – Early feeling of fullness

If you marked yes to any of the above please describe: _____

Skin

☐Yes ☐No – Rashes ☐Yes ☐No – Itching ☐Yes ☐No - Dryness

☐Yes ☐No – Excessive Sweating ☐Yes ☐No – Hair Loss ☐Yes ☐No – Acne

If you marked yes to any of the above please describe: _____

_____

Muscles, Joints and Bones

☐Yes ☐No – Joint Pain ☐Yes ☐No – Stiffness ☐Yes ☐No – Joint Swelling

☐Yes ☐No – Muscle pain or spasm

If you marked yes to any of the above please describe: _____

_____

Ears, Nose and Throat

☐Yes ☐No – Hearing loss ☐Yes ☐No - Ringing in ears ☐Yes ☐No – Allergy

☐Yes ☐No – Sinus congestion ☐Yes ☐No – Difficulty swallowing ☐Yes ☐No - Stuffy nose

☐Yes ☐No – Excessive sneezing ☐Yes ☐No – Chronic coughing

☐Yes ☐No – Gagging/frequent throat clearing

If you marked yes to any of the above please describe: _____

_____

Vision

☐Yes ☐No – Blurred ☐Yes ☐No – Seeing double ☐Yes ☐No – Seeing spots

If you marked yes to any of the above please describe: _____

_____

Mood

☐Yes ☐No – Sad ☐Yes ☐No – Anxious ☐Yes ☐No – Worried

☐Yes ☐No – Tense ☐Yes ☐No – Stressed ☐Yes ☐No – Hopeless

☐Yes ☐No – Angry outbursts ☐Yes ☐No – Irritability ☐Yes ☐No – Mood swings

If you marked yes to any of the above please describe: _____

_____

Urinary

☐Yes ☐No – Incontinence (trouble holding water) ☐Yes ☐No – Difficulty starting urination

☐Yes ☐No – Burning when urinating ☐Yes ☐No – Frequency, urgency (have to go to the bathroom often)

If you marked yes to any of the above please describe: _____

_____

Sexual function

☐Yes ☐No – Poor desire ☐Yes ☐No – Trouble having orgasm

☐Yes ☐No – Pain during sexual activity

If you marked yes to any of the above please describe: _____

_____

For Women Only:
Do you menstruate? ☐Yes ☐No
If yes, what was the first day of your last menstrual period? Date: _____
If not, age period stopped: _____

Do you use birth control? ☐Yes ☐No
If yes, what type? _____

Gynecologic Problems
☐Yes ☐No – Endometriosis ☐Yes ☐No – Fibroids

☐Yes ☐No – Abnormal Pap smear ☐Yes ☐No – Other _____ ☐Yes ☐No – Other _____

If you marked yes to any of the above please describe: _____

_____

	Yes	No	Clinician Comments *(for office use only)*
Heavy vaginal discharge			
Heavy menstrual bleeding			
Hot Flashes			
Pain with sex			
Low sexual desire			
Pain/Cramping during Period			
Bleeding between Periods			
Other			

PREVENTIVE CARE

IMMUNIZATIONS
When was your last tetanus shot? _____/_____/_____

☐Yes ☐No – Do you have an annual flu vaccine?

Date of last flu vaccine? _____/_____/_____

☐Yes ☐No – Have you had a pneumococcal vaccine (Pneumovax)?

Date of last pneumococcal vaccine? _____/_____/_____

☐Yes ☐No – Have you had a shingles vaccine (Zostavax)?

Date of last shingles vaccine? _____/_____/_____

DIAGNOSTIC STUDIES

Test	Month/Year	Comments
Bone Densitometry		
Sigmoidoscopy or Colonoscopy		
Mammogram		
Pelvic Exam/Pap Smear		
PSA (Prostate Specific Antigen)		

LABORATORY AND IMAGING STUDIES NOTE:
If you are not receiving health care through the UF/Shands Health Care system and you have copies of these reports at home, please bring them with you at the visit.

PERSONAL AND SOCIAL HISTORY

1. Where were you born and raised? _____
2. Describe your relationships with your parents and siblings: _____

   _____
3. How much education have you had? _____
4. Are you currently in a committed relationship? ☐Yes ☐No

   If yes, for how long? _____

   Name of your spouse or partner: _____
5. On a scale of 1-10 with 1 being Strongly Dissatisfied and 10 being Strongly Satisfied, please rate how satisfied you are with this relationship:

   1 2 3 4 5 6 7 8 9 10
6. Are you sexually active? ☐Yes ☐No

   If yes, please rate how satisfied you are with your sexual life on a scale of 1-10 with 1 being Strongly Dissatisfied and 10 being Strongly Satisfied:

   1 2 3 4 5 6 7 8 9 10
7. How many children do you have or have raised?

   Names and ages: _____
8. Who do you currently live with? Please include all people and pets: _____

   _____
9. Do you feel safe where you live? ☐Yes ☐No
10. Are you a part of a community such as a church, volunteer/service organization? ☐Yes ☐No

    If yes, please list: _____
11. Who are the most important people in your life at this time? _____

    _____
12. Do you have ongoing or past relationship issues/concerns? ☐Yes ☐No
13. Which relationship(s) support or nourish you at this time? _____

    _____

WORK HISTORY

1. Are you currently employed? ☐Yes ☐No

If yes, please describe your current job and your average number of hours of work per week: _____

_____

2. On a scale of 1-10 with 1 being Strongly Dissatisfied and 10 being Strongly Satisfied, please rate how satisfied you are with your job at this time?

   1 2 3 4 5 6 7 8 9 10

3. If you are not satisfied with your current work, what would you like to do instead? _____

   _____

4. Have you had other jobs/careers in the past? ☐Yes ☐No

   If yes, please list: _____

5. If you're currently unemployed, please indicate the reason(s), and describe how you spend your daytime hours. _____

   _____

6. How would you describe your work life/home life balance at this time? _____

   _____

7. Has your health affected your ability to perform work optimally? ☐Yes ☐No

   If yes, what do you want to improve? _____

NUTRITION AND ENVIRONMENTAL/TOXIN EXPOSURE

1. What are your favorite foods? _____

2. What foods do you dislike or unwilling to eat? _____

3. What are your food cravings, if any? _____

4. Have you ever had an eating disorder? ☐Yes ☐No

   If yes, please describe date of onset and treatment received:_____

5. Please describe what you **typically** eat each day:

   Breakfast: _____

   Lunch: _____

   Dinner: _____

   Snacks: _____

   Beverages: _____

6. Are you satisfied with your current eating habits? ☐Yes ☐No

   If not, what do you want to improve? _____

7. Have you had any prolonged exposure recently or in the past to the following?
   ☐Yes ☐No - Heavy metals (i.e. lead, mercury)
   ☐Yes ☐No - Pesticides and herbicides

☐Yes ☐No - Radiation
☐Yes ☐No - Radon
☐Yes ☐No - Molds

8. Do you consume organic food predominantly? ☐Yes ☐No

9. What is your water source? _____

10. Do you currently smoke or use products containing nicotine? ☐Yes ☐No

    If yes, how much (packs/day)? _____

    For how long? _____

11. Did you previously smoke or use nicotine? ☐Yes ☐No

    If yes, for how long? _____

    When did you quit? _____

12. Do you consume alcohol? ☐Yes ☐No

    If yes, how much? _____

    For how long? _____

13. Do you currently use illicit drugs? ☐Yes ☐No

    If yes, which ones and how often? _____

14. Did you use illicit drugs in the past? ☐Yes ☐No

    If yes, which ones and when did you quit? _____

PHYSICAL ACTIVITY, FUNCTION AND REST

1. On a scale of 1-10 with 1 being Not Physically Active and 10 being Very Physically Active, please rate how physically active you are currently:

   1 2 3 4 5 6 7 8 9 10

2. Describe your physical activity to include type of activity (i.e. aerobic or strengthening exercises and recreational activities), frequency, and duration

Physical Activity	Frequency	Duration

3. Are you satisfied with your level of physical activity? ☐Yes ☐No

   If not, what limits this? _____

   What do you want to improve? _____

4. Has your health limited your ability to perform basic, daily activities? ☐Yes ☐No

If yes, please list which ones: _____

5. How many hours of sleep do you usually get at night? _____

6. Describe sleeping difficulties, if any (i.e. difficulty falling asleep, staying asleep, not feeling rested, restless sleeping) _____

EMOTIONAL AND MENTAL HEALTH

1. On a scale of 1-10 with 1 being No Emotional and Mental Stress and 10 being High level of Emotional and Mental Stress, please rate your emotional and mental stress at this time:

   1 2 3 4 5 6 7 8 9 10

2. What are your main sources of stress at this time?
   ☐Yes ☐No - Personal
   ☐Yes ☐No - Work
   ☐Yes ☐No - Home
   ☐Yes ☐No - Other Please list _____

3. On a scale of 1-10 with 1 being Not effective at managing stress and 10 being Highly Effective at managing stress, please rate how well you manage stress in your life:

   1 2 3 4 5 6 7 8 9 10

4. What specific practice/s do you use to cope with stress?(i.e. meditation, prayer, exercise, journaling, gardening) _____

5. What are your strengths? _____

SPIRIT AND SOUL

1. What brings you joy? _____

2. What makes you laugh? _____

3. What helps you get through difficult times in your life? _____

4. What personal or professional accomplishments are you most proud of? _____

   _____

5. What are you most grateful for? _____

6. Do you have sense of purpose or meaning for your life? ☐Yes ☐No

   If yes, what is this purpose or meaning? _____

7. Do you participate in activities that are part of a religious or spiritual community? ☐Yes ☐No

   If yes, please describe. _____

8. On a scale of 1-10 with 1 being Plays No Role and 10 being Plays a Major Role, please rate how much influence your spirituality plays in how you take care of your health:

   1 2 3 4 5 6 7 8 9 10

9. Would you like your health care provider to address spiritual issues with you? ☐Yes ☐No
   If yes, how would you like us to address these? _____

OTHER INFORMATION

Thank you for completing this form.
We look forward to working with you to achieve optimal health and well-being!