

# Integrative Healthcare Providers

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**Please fill out this questionnaire as thoroughly as possible. Doing so helps us make efficient use of our time together and gives me more time for hands-on evaluation and treatment during your first appointment.**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date of Visit: \_\_\_\_\_ Phone # \_\_\_\_\_  
Primary care / referring physician info: (Name) \_\_\_\_\_ (Phone #) \_\_\_\_\_  
(Address) \_\_\_\_\_ (Fax #) \_\_\_\_\_

## **REASONS FOR TODAY'S EVALUATION:**

What are the most significant symptoms or medical needs affecting you at this time? (Please list date of onset)

1. \_\_\_\_\_

Is this concern (please circle):    occasional        frequent        constant        intermittent        other \_\_\_\_\_

What makes it better: \_\_\_\_\_

What makes it worse: \_\_\_\_\_

Please rate on a scale of 0 to 10 (0 = no symptom, 10 = symptom at its worst) how your symptoms are:

Currently                      0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

At your best                      0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

At your worst                      0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

2. \_\_\_\_\_

Is this concern (please circle):    occasional        frequent        constant        intermittent        other \_\_\_\_\_

What makes it better: \_\_\_\_\_

What makes it worse: \_\_\_\_\_

Please rate on a scale of 0 to 10 (0 = no symptom, 10 = symptom at its worst) how your symptoms are:

Currently                      0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

At your best                      0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

At your worst                      0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Do these interfere with your sleep, eating, or daily activities?    No    Yes

Describe? \_\_\_\_\_

Are the problems becoming (please circle):    Worse    Better    Unchanged    Unsure

Describe? \_\_\_\_\_

Prior evaluation and treatment for these problems: \_\_\_\_\_

## **MAJOR EVENTS, HOSPITALIZATIONS, OR SURGERY:**

Please list all major/minor surgeries or hospitalizations you have had and their approximate dates.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:**

Please list all known environmental or chemical allergies/sensitivities and their reactions.

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Please list all known drug allergies/sensitivities and their reactions.

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**MEDICAL HISTORY:**

Please check all medical conditions for which you have been treated. If you are currently being treated, write "current" or "chronic"

- Coronary artery disease
- Diabetes --- Type 1 \_\_\_\_\_ or Type 2 \_\_\_\_\_?
- Cancer --- Location/type \_\_\_\_\_
- Asthma / Allergies
- Other lung disease (ex. emphysema, chronic bronchitis)
- Hypertension
- Mood Disorder (ex. depression, anxiety, temper issues)
- Digestion problems / constipation / abdominal pain
- Back pains
- Headaches
- Arthritis --- Type \_\_\_\_\_
- Congenital anomalies
- Medical emergency or injury
- Other \_\_\_\_\_

**PAST RESULTS:** (if applicable)

Electrocardiogram and/or exercise test: \_\_\_\_\_

Hemoglobin A1C: \_\_\_\_\_

Cholesterol: \_\_\_\_\_

X-Rays: \_\_\_\_\_

Other Imaging: \_\_\_\_\_

**HEALTH MAINTENANCE:**

Please list the dates of your last health maintenance exams/procedures. (Approximate if not certain)

Colonoscopy: \_\_\_\_\_

Pelvic exam / Pap smear: \_\_\_\_\_

Mammogram: \_\_\_\_\_

Tetanus booster: \_\_\_\_\_

Bone densitometry: \_\_\_\_\_

Prostate specific antigen (PSA): \_\_\_\_\_

Have you had a pneumococcal vaccine? Yes \_\_\_\_\_ No \_\_\_\_\_. Shingles vaccine? Yes \_\_\_\_\_ No \_\_\_\_\_.

**MEDICATIONS:**

Please list all of your current medications and supplements, as well as their doses. If you have any allergies to specific medications please make sure to list and describe them in the given section above.

MEDICATIONS	DOSAGE	TIMES / DAY	STARTED	ORDER BY	PURPOSE
SUPPLEMENT / OTHER					

**FAMILY HISTORY:**

Please list all significant health issues in your family. (e.g., heart disease, depression, birth defects, arthritis, cancer, allergies)

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

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

**Brothers/Sisters:** \_\_\_\_\_

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

**SOCIAL HISTORY:**

What is/was your occupation? \_\_\_\_\_ How many hours per week? \_\_\_\_\_

Do you enjoy your work? Please explain: \_\_\_\_\_

\_\_\_\_\_

Do you smoke? Or have you ever?    No    Yes    If yes, how much do you, or have you, used?  
# of packs of cigarettes per day: \_\_\_\_\_ # of years: \_\_\_\_\_ Quit date, if applicable: \_\_\_\_\_

Do you consume alcohol?    No    Yes    If yes, how much do you, or have you, consumed?  
# of drinks per day: \_\_\_\_\_ type: \_\_\_\_\_ # of years: \_\_\_\_\_ Quit date, if applicable: \_\_\_\_\_

Do you use recreational drugs? Or have you in the past?    No    Yes

Have you ever had dependency to alcohol, recreational, drugs, or prescription medication?    No    Yes

Have you ever been injured or hit by another person?    No    Yes

If yes, are injuries still occurring or just in the past? \_\_\_\_\_

Would you like to talk more about it with our staff or other professionals?    No    Yes

Do you exercise regularly?    No    Yes    Please briefly describe your exercise and other physical activities (e.g. type, duration, frequency). \_\_\_\_\_

How many hours of sleep do you get most days? \_\_\_\_\_

How would you describe the quality of sleep?    Good    Fair    Poor    Do you feel rested after sleeping?    No    Yes

Please describe any difficulties you may have falling or staying asleep. \_\_\_\_\_

Are you married?    No    Yes    How many children? \_\_\_\_\_    Are you happy? \_\_\_\_\_

Describe your current living situation. \_\_\_\_\_

Are you satisfied with your current:

Sex life?    No    Yes                      Social life?    No    Yes                      Spiritual life?    No    Yes

Do you have a lot of personal stress?    No    Yes                      What strategies do you use to manage stress? Please explain: \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Please indicate if you have had any problems related to the following:

**Constitutional:** Weight loss or weight gain, night sweats, fatigue, unexplained fevers, etc.

**Nervous System:** Seizures, numbness, mental fog, weakness, etc.

**HEENT:** Ringing in the ear, decreased hearing, dizziness, sore throat, etc.

**Cardiopulmonary:** Shortness of breath, decreased exercise tolerance, chest pain, etc

**GI:** Indigestion, ulcers, constipation, diarrhea, etc.

**GU:** Infections, incontinence, excessive or painful urination, etc.

**Musculoskeletal:** Stiffness or swelling of the joints and/or muscles, etc.