Integrative Healthcare Providers

(New Patient History Questionnaire for patients 15 and over)

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.

_____

_____

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

_____

_____

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.