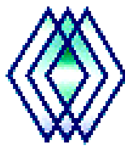



# The Center for Integrative Healthcare & Healing

## Integrative Healthcare Intake Form

Name ________________________________ Date of Birth ____________ Date __________

What brings you in to see us today? ____________________________________________

Who referred you/how did you hear about us? _____________________________________

What would you like to address today?

| | Concern | Onset | Frequency | How this impacts your life |
|---|---|---|---|---|
| 1. | ____________ | ________ | ________ | ________ |
| 2. | ____________ | ________ | ________ | ________ |
| 3. | ____________ | ________ | ________ | ________ |
| 4. | ____________ | ________ | ________ | ________ |
| 5. | ____________ | ________ | ________ | ________ |

Please describe your previous experiences with alternative or complementary medicine (e.g. acupuncture, naturopathy, massage therapy, Reiki, hypnotherapy, etc)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

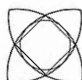
## Mind/Body

With whom do you live? _____________________________________________
What pets do you live with? __________________________________________
Do you feel safe in your home? _______________________________________
What is your occupation? ____________________________________________
Are you, or were you, married or partnered? ____________________________
What are the ages of your children? __________________________________
Who are the most important people in your life? _________________________

PERSONAL MEDICAL HISTORY

Please list any surgical procedures/operations/major injuries:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________



PERSONAL MEDICAL HISTORY (continued)

Please check the following conditions that apply to you and circle appropriate choices when given.

______ Alcoholism or Substance Abuse
______ Anemia
______ Arthritis
______ Asthma
______ Blood clots
______ Cancer (Type ____________________________)
______ Chemotherapy
______ COPD
______ Depression
______ Diabetes
______ Digestive (Crohn's, IBS, Ulcerative Colitis)
______ Easy Bleeding
______ Fibromyalgia
______ Frequent Sinusitis
______ Gall Bladder Problems
______ GERD
______ Hay Fever, Allergies, Eczema
______ Hepatitis
______ Heart Attack, Heart Disease, Heart Failure
______ Heart Murmur
______ Headaches (Migraines, Tension)

______ High Blood Pressure
______ High Cholesterol
______ History of Infertility
______ Kidney Infections/Stones
______ Pneumonia
______ Organ Transplant
______ Rheumatic Fever
______ Seizures, Epilepsy
______ Serious Injury/Accident (Type _____________)
______ Sexually Transmitted Disease
(Chlamydia, Warts, Herpes)
(Specify Other __________________________)
______ Skin Disease
______ Stroke
______ Thyroid Disease (Specify _________________)
______ Tuberculosis (TB)
______ Urinary Problems (Incontinence, Infections)
______ Vision Problems
______ Other (Specify) _________________________
______ Other (Specify) _________________________
______ Other (Specify) _________________________

WOMEN ONLY

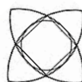
**Reproductive History**

Age at first menstrual period _____
Date of last menstrual period _____
Usual Flow: _____ Heavy _____ Moderate _____ Light
Length of period in days _____
Number of days between periods ______
Do you have (please circle): Painful Periods, Missed Periods, Spotting between Periods, Vaginal Bleeding, Unusual Discharge/Infections, Recurrent Vaginal Infections
If you have gone through menopause, have you had any post-menopausal bleeding? ______________________
Date of last Pap smear __________________________
History of Abnormal Pap smears? _________________

**Contraceptive History** (Please circle)

Birth Control Pills Type _________ Duration _____
Diaphragm/Cap Type _________ Size _________
IUD Type _________ Last Change ___
Norplant, Condom and/or Foam, Suppository
Tubal Ligation, Hysterectomy, Partner with Vasectomy
Other_____________________________________________
Problems with current method ____________________
_____________________________________________

Number of: Pregnancies _________ Live Births _________ Abortions ________ Miscarriages _________
Sexual Orientation: ______ Heterosexual _______ Homosexual _______ Bisexual _______ Transgender



MEN ONLY

Do you have: _____ Prostate Problems _____ Sexual Dysfunction (low libido, impotence)
_____ Vasectomy _____ Testicular Cancer

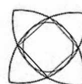
Sexual Orientation: ______ Heterosexual _______ Homosexual _______ Bisexual _______ Transgender

REVIEW OF SYSTEMS

Please check or circle any of the following symptoms that apply to you.

| General |
|---|
| Fatigue |
| Difficulty sleeping |
| Weight loss or weight gain |
| Eyes/Ears/Nose/Throat/Sinuses |
| Blurred vision |
| Hearing loss or ringing in ears |
| Frequent infections |
| Pain |
| Frequent throat clearing or post-nasal drainage |
| Heart/Circulation |
| Chest discomfort (pain/pressure/tightness) |
| Palpitations |
| Leg swelling |
| Lungs |
| Shortness of breath |
| Wheezing |
| Cough |
| Digestion/Elimination |
| Heartburn/Reflux |
| Nausea/Vomiting |
| Abdominal bloating |
| Abdominal pain/cramping |
| Excessive belching or gas |
| Constipation |
| Diarrhea |
| Kidneys/Bladder/Urination |
| Urgency or increased frequency |
| Pain or burning with urination |
| Difficulty urinating |
| Blood in the urine |
| Leakage |
| Frequent infections |

| Muscles/Bones/Joints |
|---|
| Muscle pain |
| Muscle cramps or spasms |
| Joint pain/stiffness/swelling |
| Low back pain |
| Neck pain |
| Other: |
| Nervous System |
| Headaches |
| Dizziness |
| Balance problems |
| Weakness/Numbness/tingling |
| Difficulty concentrating |
| Memory problems |
| Allergies/Immune System |
| Seasonal allergies |
| Food allergies |
| Other: |
| Hormonal/Endocrine |
| Cold or heat intolerance |
| Night sweats |
| Excessive thirst |
| Excessive hunger |
| Blood |
| Easy bruising |
| Abnormal bleeding |
| Skin |
| Rashes |
| Eczema |
| Psychiatric/Psychological |
| Depression |
| Anxiety or panic attacks |
| Suicidal thoughts |



FAMILY MEDICAL HISTORY

| | **List family members who have or had this illness.** |
|---|---|
| Arthritis | |
| Alcoholism or Substance Abuse | |
| Cancer:  Breast | |
| Cancer:  Colon | |
| Cancer:  Other | |
| Depression or other Mental illness | |
| Diabetes | |
| Glaucoma | |
| High Blood Pressure | |
| Heart Disease | |
| High Cholesterol | |
| Kidney Disease | |
| Liver Disease (Hepatitis, etc) | |
| Lung Disease (Asthma, COPD, etc.) | |
| Stoke | |
| Thyroid Disease | |
| Other: | |
| Other: | |
| Other: | |

## Lifestyle/Behavior

What are the major stressors in your life? ______________________________

______________________________

______________________________

How do you relax/relieve stress? ______________________________

______________________________

What physical activity do you participate in?  How often? ______________________________

______________________________

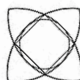
What leisure activities/hobbies do you enjoy? ______________________________

Do you have a spiritual or religious practice? ______________________________

What brings meaning to your life? ______________________________

Describe your sleep patterns. ______________________________

Describe your overall energy level. ______________________________



| | Amount Per Day | Amount Per Week | Never Used |
|---|---|---|---|
| **Tobacco** | | | |
| Cigarettes | ______ | ______ | ______ |
| Cigars/Pipe | ______ | ______ | ______ |
| Chewing | ______ | ______ | ______ |
| **Alcohol** | ______ | ______ | ______ |
| **Recreational Drugs** | ______ | ______ | ______ |

## NUTRITION

How many meals do you eat per day? ______________________________
Who does the food shopping in your home? ______________________________
Who prepares the food in your home? ______________________________
How often do you cook? ______________________________
Which meals do you regularly eat outside your home? ______________________________
Are you currently on a special diet? ______________________________
Do you have any sensitivities to food or avoid any foods? ______________________________
______________________________
How often to you eat fast food? ______________________________
Which foods do you regularly crave? ______________________________
What and how much do you drink on a typical day? ________ water _______ caffeine _______ ________ other
How would you describe your relationship with food? ______________________________
______________________________

Please provide an overview of your current diet to help us assess your nutritional needs. In each category, provide the type and amount you consume weekly. (EXAMPLE: FRUITS - bananas, apples, blueberries, grapes, etc.)

FRUITS ______________________________

VEGETABLES ______________________________

BEANS ______________________________

SALAD GREENS ______________________________

NUTS/SEEDS ______________________________

GRAINS ______________________________

OILS ______________________________

BEVERAGES ______________________________

DAIRY ______________________________

FISH ______________________________

MEATS ______________________________

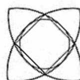
BREADS ______________________________

CEREALS ______________________________

PASTA ______________________________

SOY PRODUCTS ______________________________

SNACKS ______________________________



## MEDICATIONS

What medications are you currently taking? (Include prescription drugs and over the counter drugs.)

| Medication | Dose | Reason for Use | When Started |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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| | | | |

What vitamins/minerals/herbal supplements are you currently taking?

| Brand or Other Name | Dose | Reason for Use | When Started |
|---|---|---|---|
| | | | |
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Is there any other information that you would like us to know? ______________________________

______________________________________________________________________

______________________________________________________________________

"It is more important to know what sort of patient has a disease than what disease a patient has."

*Sir William Osler*