GOTTFRIED | CENTER

FOR INTEGRATIVE MEDICINE

PATIENT INTAKE FORM

Date ________________

Demographic Data

Patient Name ____

Address ____

City ____________________ State ____________________ Zip ____________________

Home Phone ____________________ Business Phone ____________________ Mobile Phone ____________________

Email ____

Sex ____________________ Date of Birth ____________________ Age ____________________

Emergency Contact Info

Name ______________________________ Relationship ____________________

Home Phone ____________________ Business Phone ____________________ Mobile Phone ____________________

Current Medical Team (Please list name and phone number of each practitioner)

Primary Physician ______________________________ Phone ____________________

Dentist ______________________________ Phone ____________________

Eye Doctor ______________________________ Phone ____________________

Ob/Gyn ______________________________ Phone ____________________

Preferred Pharmacy ______________________________ Phone ____________________

Other ______________________________ Phone ____________________

Health History

What brings you to the Center for Integrative Medicine?

____

What are your health goals?

____

A: Serious Childhood Illnesses (Please Describe)

____

____

B: Previous Medical Illnesses Including Surgery And Hospitalizations

Event ____________________ Place ____________________ Date __________

Event ____________________ Place ____________________ Date __________

Event ____________________ Place ____________________ Date __________

C: Women's Health History

Number of Pregnancies __________ Number of Children __________ Children's Ages __________

Age at start of periods __________ Age at end of periods/menopause __________

Menses (Check all that apply) ❑ Regular ❑ Irregular ❑ Painful ❑ PMS ❑ Other (Describe Below)

____

D: Allergies

Do you have an ALLERGY to a drug or other substance? ❑ **NO** ❑ **YES** (Describe Below)

____

E: Antibiotics

How often have you taken antibiotics?

Infant/Childhood	❑ More than five times	❑ Less than five times
Teen	❑ More than five times	❑ Less than five times
Adulthood	❑ More than five times	❑ Less than five times

F: Oral Steroids

How often have you taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

Infant/Childhood ______________________

Teen ______________________

Adulthood ______________________

G: Current Medicine Used

Drug Name ______________________ Strength ______________ Dosage ______________

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Drug Name ______________________ Strength ______________ Dosage ______________

Drug Name ______________________ Strength ______________ Dosage ______________

Drug Name ______________________ Strength ______________ Dosage ______________

H: Diagnostic Studies

Have you ever had diagnostic studies? ❑ **NONE** ❑ **LISTED BELOW** (Check All That Apply)

❑ Upper G.I. (Stomach X-Ray) Year ________ Result ______________________

❑ IVP (Kidney X-Ray Year ________ Result ______________________

❑ Gall Bladder Year ________ Result ______________________

❑ Barium Enema (Colon X-Ray) Year ________ Result ______________________

❑ Electrocardiogram Year ________ Result ______________________

❑ Other (Describe Below)

____

____

____

I: Immunizations

❑ Measles-Mumps-Rubella

❑ Polio

❑ Tetanus & Diptheria

❑ Chicken Pox

❑ Pneumovax

❑ Tetanus Booster

❑ DPT

❑ Influenza

❑ Hepatitis A

Series #1 ❑ #2 ❑

❑ Hepatitis

B Series #1 ❑ #2 ❑ #3 ❑

J: Toxic Metals

Have you, to your knowledge, been exposed to toxic metals in your job or at home? ❑ **NO** ❑ **YES** (Check Below)

❑ Lead ❑ Arsenic ❑ Aluminum ❑ Cadmium ❑ Mercury

K: Dental

Do you have dental amalgams (silver fillings) or root canals? ❑ **NO** ❑ **YES**

L: Family History

Please tell us about your family. Please include any family member with a history of tuberculosis, diabetes, cancer, emphysema, kidney disease, ulcer, stroke, nervous breakdown, and gallbladder disease.

Relation	How Many	Age	Health Problem	Age at Death	Cause of Death
Mother					
Maternal Grandmother					
Maternal Grandfather					
Father					
Paternal Grandmother					
Paternal Grandfather					
Sisters					
Brothers					
Daughters					
Sons					
Other					
Other					
Other					

M: Emotional Well-Being

How well have things been going for you at school? ❑ Very Well ❑ Fair ❑ Poorly ❑ Very Poorly ❑ Doesn't Apply

…with close friends? ❑ Very Well ❑ Fair ❑ Poorly ❑ Very Poorly ❑ Doesn't Apply

…with your children? ❑ Very Well ❑ Fair ❑ Poorly ❑ Very Poorly ❑ Doesn't Apply

…at your job? ❑ Very Well ❑ Fair ❑ Poorly ❑ Very Poorly ❑ Doesn't Apply

…with sex? ❑ Very Well ❑ Fair ❑ Poorly ❑ Very Poorly ❑ Doesn't Apply

…with your parents? ❑ Very Well ❑ Fair ❑ Poorly ❑ Very Poorly ❑ Doesn't Apply

…with your social life? ❑ Very Well ❑ Fair ❑ Poorly ❑ Very Poorly ❑ Doesn't Apply

…with your attitude? ❑ Very Well ❑ Fair ❑ Poorly ❑ Very Poorly ❑ Doesn't Apply

…with your spouse/partner? ❑ Very Well ❑ Fair ❑ Poorly ❑ Very Poorly ❑ Doesn't Apply

N: Social and Socioeconomic History

Years of Education ______________________ Highest Degree ______________________

Occupation ______________________ Employer ______________________

Present marital status ❑ Single ❑ Partnered ❑ Married ❑ Divorced ❑ Widowed

Spouse/Partner's Name ______________________

Number of children? ___________ Ages? ______________________ Total household, including your children? ________

O: Tobacco, Alcohol, Recreational Drug Use

Do you use tobacco in any way? ❑ **NO** ❑ **YES** If yes, frequency? ______________________

If yes, are you interested in quitting? ❑ **NO** ❑ **YES**

Have you smoked in the past? ❑ **NO** ❑ **YES** If yes, when did you stop? ______________________

Do you drink alcoholic beverages? ❑ **NO** ❑ **YES** If yes, frequency? (Drinks per week) ______________________

Do you use recreational drugs? ❑ **NO** ❑ **YES** If yes, type? ______________________

If yes, are you interested in quitting? ❑ **NO** ❑ **YES**

P: Sexual Activity

Are you sexually active? ❑ **NO** ❑ **YES** Birth control method? ____________________ Practice safe sex? ❑ **NO** ❑ **YES**

Q: Energy Levels

Describe your energy level throughout a typical day rating on a scale of **1-10** **1** = Extreme Fatigue / **10** = Feeling Great And Energized

____ Early Morning ____ Mid Morning to Noon ____ Mid Afternoon ____ Evening

Describe any associated food or drink cravings (sugar, coffee, cola's etc):

___

R: Alternative Medical Treatment

Do you use over the counter medicines, vitamins, herbs, and food supplements? ❑ **NO** ❑ **YES** (If yes, describe below)

___

Have you seen a practitioner of alternative medicine? ❑ **NEVER** ❑ **IN THE PAST 12 MONTHS** ❑ **MORE THAN ONE YEAR AGO**
Please check any practices you have tried:

- ❑ Acupuncture
- ❑ Chelation Therapy
- ❑ Homeopathy
- ❑ Neuro-Linguistic Programming
- ❑ Aroma Therapy
- ❑ Environmental Medicine
- ❑ Hypnosis
- ❑ Nutritional Medicine
- ❑ Ayurvedic Medicine
- ❑ Fasting
- ❑ Light Therapy
- ❑ Orthomolecular Biofeedback
- ❑ Guided Imagery
- ❑ Meditation
- ❑ Traditional Chinese Medicine
- ❑ Bodywork
- ❑ Herbal Medicine
- ❑ Naturopathy
- ❑ Yoga Other

S: Nutrition Evaluation

Please list all foods and drinks you have consumed in the past 24 hours. Include meals, snacks, beverages and condiments.

Food Item	How Prepared (Baked, Fried, Etc.)	Amount (Cup, Tbs., Oz., Etc)

Is this a typical day? ❑ **NO** ❑ **YES** If not, please describe why:

___

How many servings of fruit do you eat/drink each day? ___
(Serving = 1 small piece of fruit, 1 cup juice, 1 cup canned or chopped fruit, 1 cup dried fruit)

How many servings of vegetables do you consume each day? ___
(Serving = 1 cup raw or cooked vegetables, 1 cup fresh, green leafy vegetables, 1 cup dried vegetables, or 1 small piece)

Are you currently on a special diet? ❑ **NO** ❑ **YES** If so, please describe:

___

Do you eat meat? ❑ **NO** ❑ **YES** If yes, what kind and how much?

___

What type of oil or spreads do you add to your food? ___

What do you drink on a typical day? ___

How would you describe your relationship with food? ___

___

Is there anything special about your diet that we should know? ❑ **NO** ❑ **YES** (If yes, please explain.)

____

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.? ❑ **NO** ❑ **YES**

If yes, are these symptoms associated with any particular food or supplement(s)? ❑ **NO** ❑ **YES**
(Please name the food or supplement and symptoms(s). Example Milk = gas & diarrhea)

____

Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc? ❑ **NO** ❑ **YES**

Does skipping a meal greatly affect your symptoms? ❑ **NO** ❑ **YES**

Have you ever had a food that you craved or really "binged" on over a period of time? (food craving may be an indicator that you may be allergic to that food) ❑ **NO** ❑ **YES** If yes, what food(s)?

____

Do you have an aversion to certain foods? ❑ **NO** ❑ **YES** If yes, what foods?

____

T: Review of Systems

Please check any current symptoms you may have

Constitutional

❑ Recent Fever Or Sweats
❑ Unexplained Weight Loss/Gain
❑ Unexplained Weakness/Fatigue
❑ Decline In Libido

Respiratory

❑ Cough/Wheeze
❑ Coughing Up Blood

Skin

❑ Rash
❑ New Or Change In Mole
❑ Thin, Ridged, Or Splitting, Crumbling Nails

Eyes

❑ Changes In Vision

Gastrointestinal

❑ Heartburn/Reflux
❑ Blood Or Change In Bowel Movement
❑ Nausea/Vomiting/Diarrhea
❑ Pain In Abdomen
❑ Irritable Bowel Syndrome/Digestion Problems

Neurological

❑ Headaches
❑ Memory Loss
❑ Fainting

Ears/Nose/Throat/Mouth

❑ Difficultly Hearing
❑ Hay Fever/Allergies
❑ Trouble Swallowing

Cardiovascular

❑ Chest Pains/Discomfort
❑ Palpitations
❑ Short Of Breathe With Exertion

Genitourinary

❑ Painful/Bloody Urination
❑ Leaking Urine
❑ Nighttime Urination
❑ Unusual Vaginal Bleeding
❑ Concern With Sexual Function

Psychiatric

❑ Anxiety/Stress
❑ Sleep Problem
❑ Depression

Blood/Lymphatic

❑ Unexplained Lumps
❑ Easy Bruising/Bleeding

Breast

❑ Breast Lump
❑ Nipple Discharge

Musculoskeletal

❑ Muscle/Joint Pain
❑ Recent Back Pain

Endocrine

❑ Cold/Heat Intolerance
❑ Increased Thirst/Appetite

Medical Symptom Questionnaire (MSQ)

Rate each of the following symptoms based on your typical health profile for ❑ **PAST 30 DAYS** ❑ **PAST 48 HOURS**

Point System

0 = Never or almost never have the symptom
1 = Occasionally (effect is not severe)
2 = Occasionally (effect is severe)
3 = Frequently (effect is not severe)
4 = Frequently (effect is severe)

Head

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia
___ **TOTAL**

Eyes

___ Watery Or Itchy Eyes
___ Swollen, Reddened Or Sticky Eyelids
___ Bags Or Dark Circles Under Eyes
___ Blurred Or Tunnel Vision
(Not near- or far-sightedness)
___ **TOTAL**

Ears

___ Itchy Ears
___ Earaches, Ear Infections
___ Drainage From Ear
___ Ringing In Ears, Hearing Loss
___ **TOTAL**

Nose

___ Stuffy Nose
___ Sinus Problems
___ Hay Fever
___ Sneezing Attacks
___ Excessive Mucus Formation
___ **TOTAL**

Mouth/Throat

___ Chronic Coughing
___ Gagging, Frequent Need To Clear Throat
___ Sore Throat, Hoarseness, Loss Of Voice
___ Swollen Or Discolored Tongue, Gums Or Lips
___ **TOTAL**

Skin

___ Acne
___ Hives, Rashes, Dry Skin
___ Hair Loss
___ Flushing, Hot Flashes
___ Excessive Sweating
___ **TOTAL**

Joints/Muscle

___ Pain Or Aches In Joints
___ Arthritis
___ Stiffness Or Limitation Of Movement
___ Pain Or Aches In Muscles
___ Feeling Of Weakness Or Tiredness
___ **TOTAL**

Digestive

___ Nausea, Vomiting
___ Diarrhea
___ Constipation
___ Bloated Feeling
___ Belching, Passing Gas
___ Heartburn
___ Intestinal/Stomach Pain
___ **TOTAL**

Weight

___ Binge Eating/Drinking
___ Craving Certain Foods
___ Excessive Weight
___ Compulsive Eating
___ Water Retention
___ Underweight
___ **TOTAL**

Energy/Activity

___ Fatigue, Sluggishness
___ Apathy, Lethargy
___ Hyperactivity
___ Restlessness
___ **TOTAL**

Mind

___ Confusion, Poor Comprehension
___ Poor Memory
___ Poor Concentration
___ Poor Physical Coordination
___ Difficulty In Making Decisions
___ Stuttering Or Stammering
___ Slurred Speech
___ Learning Disabilities
___ **TOTAL**

Emotions

___ Mood Swings
___ Anxiety, Fear, Nervousness
___ Anger, Irritability, Aggressiveness
___ Depression
___ **TOTAL**

Other

___ Frequent Illness
___ Frequent Or Urgent Urination
___ Genital Itch Or Discharge
___ **TOTAL**

___ GRAND TOTAL