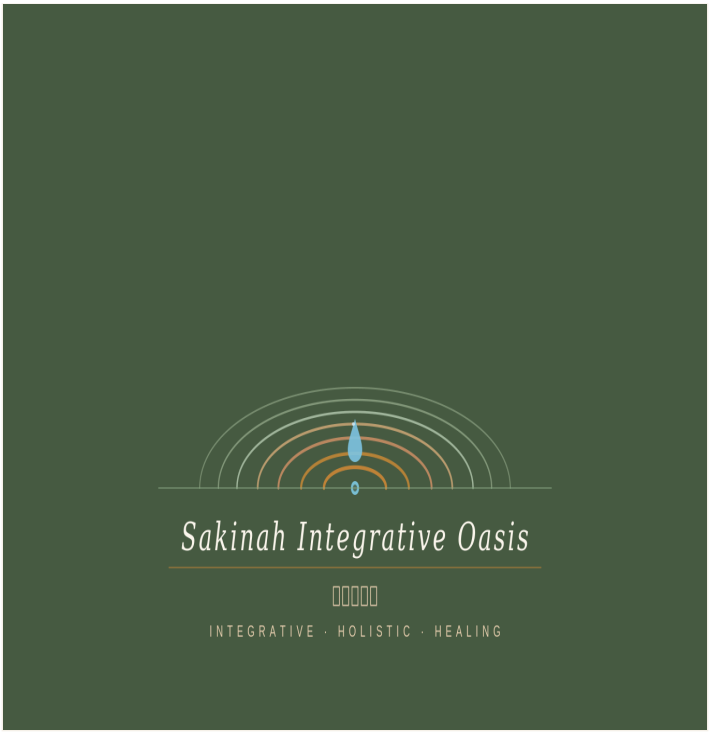
Welcome to Integrative Medicine! The following questions are designed to help us understand your overall health and well-being, address your health concerns, and identify your health goals. We seek to know the whole person by asking about your physical, emotional, mental, and spiritual health in addition to information about your medical condition/s.

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.

Please let us know if you have any questions or comments. We look forward to working with you to achieve optimal health and well-being!



GENERAL INFORMATION

Name _____ DOB _____/_____/_____

Primary Care Physician _____

Complementary and alternative medicine (CAM) providers _____

_____

Other health care 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.

_____

_____

What does being healthy look like for you?

_____

_____

Where do you get most of your health information?

☐ Health care professional ☐ Internet ☐ TV/Radio ☐ Family, friends, colleagues

GENERAL INFORMATION *continued*

On a scale of 1 (low) to 5 (high), please rate how well you understand your health condition, treatment plan and your role in your health: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Explain why you rated yourself this way:

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

currently taking:

Name of Medication	Dosage	Reason for taking	Frequency

PAST TREATMENTS THAT HAVE NOT WORKED

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

Name of Medication	Supplements/Herbs	Food	Environmental

PREVENTIVE CARE

IMMUNIZATIONS

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

Do you have an annual flu vaccine? ☐ Yes ☐ No Date of last flu vaccine? _____/_____/_____

Have you had a pneumonia vaccine? ☐ Yes ☐ No Date of last pneumococcal vaccine? _____/_____/_____

Have you had a shingles vaccine? ☐ Yes ☐ No 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 have recent labs and imaging, please upload copies of these reports in the patient portal.

FAMILY HISTORY: Please list any health problems with your family members

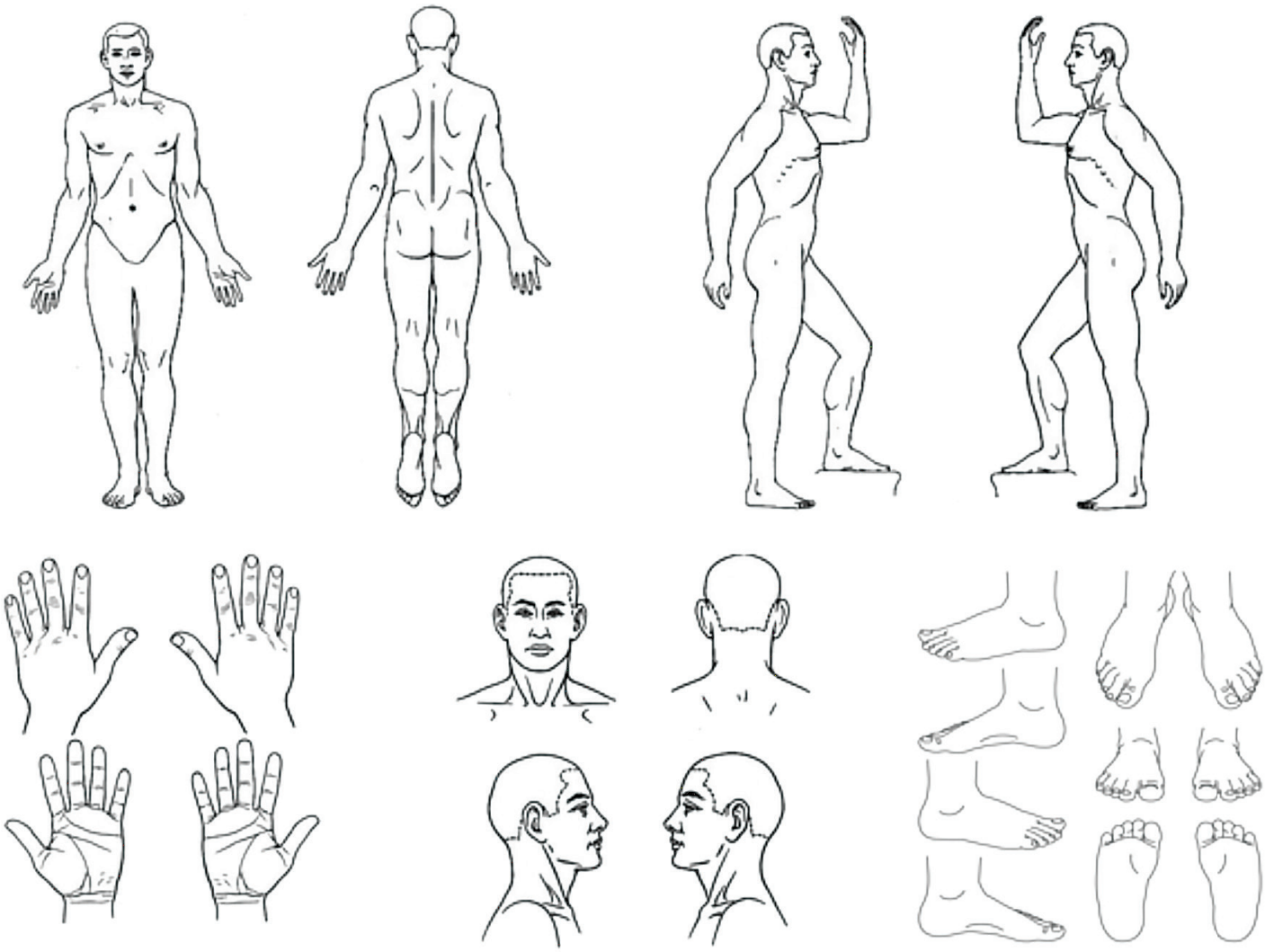
Mother	Father	Sister/s	Brother/s	Grandparents	Other

PAIN (Complete only if your chief concern for today's visit is pain)

Please read carefully: Mark the areas on the diagram below that coincide with your pain. Include all aff ected areas. Use as many individual symbols as you'd like to describe the pain intensity. **Indicate radiation of pain by drawing an arrow (→) from the origin of pain to where it stops.**

Use the appropriate symbol(s) listed below:

ACHING: XXXX	NUMBNESS: ----	PINS AND NEEDLES: 0000
BURNING: >>>>	STABBING: ////	THROBBING: ++++



The lines below represent the intensity of your pain. Please number each pain (1, 2, 3, etc.) you described above starting with your greatest complaint and list these below. Then mark the line provided at the position that best indicates the intensity of pain you feel **right now**.

#1 NO PAIN _____I_____ WORST PAIN IMAGINABLE

#2 NO PAIN _____I_____ WORST PAIN IMAGINABLE

#3 NO PAIN _____I_____ WORST PAIN IMAGINABLE

REVIEW OF SYSTEMS (Only check boxes if symptoms have been present in the last 6 months)

General Health (LAST 6 MONTHS)

1. Difficulty sleeping ☐ Yes ☐ No
2. Restlessness ☐ Yes ☐ No
3. Excessive weight loss/gain ☐ Yes ☐ No
4. Low energy ☐ Yes ☐ No
5. Feel too hot or too cold ☐ Yes ☐ No
6. Hyperactivity ☐ Yes ☐ No

If you marked any of the above, please describe _____

_____

Cardiovascular (Heart) (LAST 6 MONTHS)

1. Chest pain ☐ Yes ☐ No
2. Irregular heartbeats ☐ Yes ☐ No
3. Rapid or pounding heartbeats ☐ Yes ☐ No
4. High blood pressure ☐ Yes ☐ No
5. Fainting ☐ Yes ☐ No

If you marked any of the above, please describe _____

_____

Pulmonary (Lungs) (LAST 6 MONTHS)

1. Shortness of breath ☐ Yes ☐ No
2. Chest congestion ☐ Yes ☐ No
3. Wheezing ☐ Yes ☐ No

If you marked any of the above, please describe _____

_____

Neurological (LAST 6 MONTHS)

1. Headaches ☐ Yes ☐ No
2. Weakness ☐ Yes ☐ No
3. Poor memory ☐ Yes ☐ No
4. Speech difficulties ☐ Yes ☐ No
5. Numbness ☐ Yes ☐ No
6. Difficulty walking ☐ Yes ☐ No
7. Poor coordination ☐ Yes ☐ No
8. Difficulty concentrating/focusing ☐ Yes ☐ No
9. Dizziness ☐ Yes ☐ No
10. Falling ☐ Yes ☐ No

If you marked any of the above, please describe _____

_____

REVIEW OF SYSTEMS (Only check boxes if symptoms have been present in the last 6 months) continued

Stomach and Intestines (LAST 6 MONTHS)

1. Heartburn ☐ Yes ☐ No
2. Cramping ☐ Yes ☐ No
3. Bloating ☐ Yes ☐ No
4. Diarrhea ☐ Yes ☐ No
5. Gas ☐ Yes ☐ No
6. Early feeling of fullness ☐ Yes ☐ No
7. Constipation ☐ Yes ☐ No
8. Nausea ☐ Yes ☐ No
9. Blood in stool ☐ Yes ☐ No
10. Vomiting ☐ Yes ☐ No

If you marked any of the above, please describe _____

_____

Skin (LAST 6 MONTHS)

1. Rashes ☐ Yes ☐ No
2. Excessive sweating ☐ Yes ☐ No
3. Itching ☐ Yes ☐ No
4. Hair loss ☐ Yes ☐ No
5. Dryness ☐ Yes ☐ No
6. Acne ☐ Yes ☐ No

If you marked any of the above, please describe _____

_____

Muscles, Joints and Bones (LAST 6 MONTHS)

1. Joint pain ☐ Yes ☐ No
2. Muscle pain or spasm ☐ Yes ☐ No
3. Stiffness ☐ Yes ☐ No

If you marked any of the above, please describe _____

_____

Ears, Nose and Throat (LAST 6 MONTHS)

1. Hearing loss ☐ Yes ☐ No
2. Sinus congestion ☐ Yes ☐ No
3. Excessive sneezing ☐ Yes ☐ No
4. Gagging/frequent throat clearing ☐ Yes ☐ No
5. Ringing in ears ☐ Yes ☐ No
6. Difficulty swallowing ☐ Yes ☐ No
7. Chronic coughing ☐ Yes ☐ No
8. Stuffy nose ☐ Yes ☐ No
9. Allergies ☐ Yes ☐ No

If you marked any of the above, please describe _____

_____

REVIEW OF SYSTEMS (Only check boxes if symptoms have been present in the last 6 months) continued

Vision (LAST 6 MONTHS)

1. Blurred ☐ Yes ☐ No
2. Seeing double ☐ Yes ☐ No
3. Seeing spots ☐ Yes ☐ No

If you marked any of the above, please describe _____

_____

Emotional (LAST 6 MONTHS)

1. Sad ☐ Yes ☐ No
2. Tense ☐ Yes ☐ No
3. Angry outburst ☐ Yes ☐ No
4. Anxious ☐ Yes ☐ No
5. Stressed ☐ Yes ☐ No
6. Irritability ☐ Yes ☐ No
7. Worried ☐ Yes ☐ No
8. Hopeless ☐ Yes ☐ No
9. Mood swings ☐ Yes ☐ No
10. Suicidal thoughts ☐ Yes ☐ No

If you marked any of the above, please describe _____

_____

Urinary (LAST 6 MONTHS)

1. Incontinence (trouble holding water) ☐ Yes ☐ No
2. Burning when urinating ☐ Yes ☐ No
3. Difficulty starting urination ☐ Yes ☐ No
4. Frequency, urgency (using bathroom often) ☐ Yes ☐ No

If you marked any of the above, please describe _____

_____

Sexual Function (LAST 6 MONTHS)

1. Poor desire ☐ Yes ☐ No
2. Pain during sexual activity ☐ Yes ☐ No
3. Trouble having an orgasm ☐ Yes ☐ No

If you marked any of the above, please describe _____

_____

REVIEW OF SYSTEMS (Only check boxes if symptoms have been present in the last 6 months) continued

For Females Only:

Do you have a menstrual cycle? ☐ 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 (Females Only)

1. Endometriosis ☐ Yes ☐ No
2. Fibroids ☐ Yes ☐ No
3. Abnormal pap smear ☐ Yes ☐ No
4. Heavy bleeding during menstrual cycle ☐ Yes ☐ No
5. Pain/cramping during menstrual cycle ☐ Yes ☐ No
6. Other (If yes, describe below) ☐ Yes ☐ No

If you marked any of the above, please describe _____

_____

PERSONAL AND SOCIAL HISTORY

1. What is your relationship status? ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic partnership
2. On a scale of 1 (low) to 5 (high) with 1 being Strongly Dissatified and 5 being Strongly Satisfied, please rate how satisfied you are with this relationship: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
3. Do you have any children? ☐ Yes ☐ No
   If yes, how many and what are their ages? _____
4. Who do you currently live with? Please include people and pets _____
5. Do you feel safe where you live? ☐ Yes ☐ No
6. Do you have ongoing or past relationship issues/concerns? ☐ Yes ☐ No
7. Do you currently have a strong support system? ☐ Yes ☐ No
   If yes, please explain _____
8. Describe your relationship with your parents and siblings _____

   _____
9. What is your highest level of education? _____

WORK HISTORY

1. Are you currently employed? ☐ Yes ☐ No

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

   _____

   _____

2. On a scale of 1 (low) to 5 (high), please rate how satisfied you are with your job at this time?

   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

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

4. Please rate yourself on a scale of 1 (low) to 5 (high):

   How well are you able to balance responsibilities where you live, volunteer and work? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

   What are the reasons you chose this number?

   _____

   _____

   What changes could you make to improve this?

   _____

   _____

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

   _____

6. 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. How would you rate your current healthy eating habits? ☐ Poor ☐ Fair ☐ OK ☐ Good ☐ Great
   If not great, how do you want to improve?_____
2. Have you ever had an eating disorder? ☐ Yes ☐ No
   If yes, please describe the date of onset and treatment received _____
3. Please rate yourself on a scale of 1 (low) to 5 (high):
   Ability to eat balanced meals every day with plenty of fruits and vegetables. Drinking enough water and limiting sodas, sweetened drinks and alcohol: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
   What are the reasons you chose this number?
   _____
   _____
   What changes could you make to improve this?
   _____
   _____
4. Who is the primary person who prepares/shops for your food?
5. Do you consume organic food predominately? ☐ Yes ☐ No
6. What is your water source? _____
7. Have you had any prolonged exposure recently or in the past to the following?
   ☐ Heavy metals ☐ Pesticides and herbicides ☐ Radiation ☐ Radon ☐ Mold
8. Do you currently smoke or use products containing nicotine? ☐ Yes ☐ No
   If yes, how much (packs/day)? _____ For how long? _____
9. Did you previously smoke or use nicotine? ☐ Yes ☐ No
   If yes, for how long? _____ When did you quit? _____
10. Do you consume alcohol? ☐ Yes ☐ No
    If yes, how much? _____ For how long? _____
11. Do you currently use illicit drugs? ☐ Yes ☐ No
    If yes, which ones and how often?_____
12. 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. Describe your physical activity to include type of activity (i.e. aerobic or strengthening exercises, recreational activities, yoga, walking, gardening, etc.), frequency and duration

Physical Activity	Frequency	Duration

2. How many hours of sleep do you usually get a night? _____
3. 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 (low) to 5 (high) with 1 being No Emotional and Mental Stress to 5 being High Level of Emotional and Mental Stress, please rate your emotional and mental stress at this time: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
2. What are your main sources of stress at this time?

   Personal: ☐ Yes ☐ No

   Work: ☐ Yes ☐ No

   Home: ☐ Yes ☐ No

   Other: ☐ Yes ☐ No Please list _____
3. On a scale of 1 (low) to 5 (high) with 1 being Not Effective at Managing Stress to 5 being Highly Effective at Managing Stress, please rate how well you manage stress in your life: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
4. What specific practice/s do you use to cope with stress? (i.e. meditation, prayer, exercise, journaling, gardening)

   _____
5. Please rate yourself on a scale of 1 (low) to 5 (high):

   Ability to use mind-body techniques like relaxation, breathing or guided imagery for healing and coping:
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

   What are the reasons you chose this number? _____

   _____

   What changes could you make to improve this? _____

   _____

SPIRIT AND SOUL

1. What brings you joy? _____
2. What makes you laugh? _____
3. What helps you get through difficult times? _____
4. What are you grateful for? _____
5. Please rate yourself on a scale of 1 (low) to 5 (high):
   Having a sense of purpose and meaning in your life: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
   What are the reasons you chose this number?

   _____

   _____

   What changes could you make to improve this?

   _____

   _____

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

OTHER INFORMATION

Please indicate any other medical, emotional, mental or spiritual issues that are not addressed in this form:

_____

_____

_____

_____

_____

Thank you for taking the time to complete this form.
We look forward to working with you to achieve optimal health and well-being!
For more information, please visit sakinahio.com