Pure Health Integrative Medicine

Client Intake Form

The practice of Integrative Medicine requires the understanding of clients as a whole: Mind, body and spirit. This form will provide a foundation for your experience at the Center, as it will help to stimulate areas that may need special attention during your visit.

Name: ______________________________Date of Birth:_____________ Today's Date:_____________

Referral Source:

- ❒ Physician: Dr._________________
- ❒ Self

Primary Care Physician: ____

Goals: Please list the reasons you have come to the Center for Integrative Medicine?

____

____

____

Past Medical History: Check all that apply and fill in any not listed at the end.

- ❒ Allergies
- ❒ Alzheimer's
- ❒ Anemia
- ❒ Anxiety
- ❒ Arthritis
- ❒ Asthma
- ❒ Bleeding Disorder
- ❒ Blood Clot(s)
- ❒ Breast Disease
- ❒ Broken Bone
- ❒ Cancer
  Type:______________
- ❒ Chronic Fatigue
- ❒ Chronic Pain
- ❒ Where:__________
- ❒ Chronic Sinusitis
- ❒ Depression
- ❒ Diabetes
- ❒ Diarrhea
- ❒ Diverticulitis
- ❒ Eczema
- ❒ Emphysema
- ❒ Endometriosis
- ❒ Fibromyalgia
- ❒ Gout
- ❒ Heart Disease
- ❒ Hepatitis
- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ Hypothyroidism
- ❒ Impotence
- ❒ Irritable Bowels
- ❒ Kidney Disease
- ❒ Low Testosterone
- ❒ Menopause
- ❒ Migraines
- ❒ Multiple Sclerosis
- ❒ Osteoporosis
- ❒ Panic Disorder
- ❒ Prostate Enlargement
- ❒ Reflux (GERD)
- ❒ Seizures
- ❒ Stroke
- ❒ Urinary Tract Infection
- ❒
- ❒
- ❒

Review of Current Symptoms: Please check any symptoms or concerns you have had in the last several months.

Constitutional
- ❒ Good general health
- ❒ Recent weight change
- ❒ Headaches
- ❒ Fever

Ear/Nose/Throat
- ❒ Hearing loss or ringing
- ❒ Earaches or drainage
- ❒ Sinus problems
- ❒ Nosebleeds
- ❒ Bad breath or bad taste
- ❒ Sore throat or voice change
- ❒ Swollen glands in neck

Eyes
- ❒ Eye disease or injury
- ❒ Wear glasses/contacts
- ❒ Glaucoma
- ❒ Double/blurred vision

Cardiovascular
- ❒ Chest pain or pressure
- ❒ Palpitations
- ❒ Shortness of breath lying flat
- ❒ Swelling of extremities

Respiratory
- ❒ Chronic or frequent cough
- ❒ Shortness of breath
- ❒ Asthma or wheezing

Energy
- ❒ Forgetful
- ❒ Poor concentration
- ❒ Fatigue
  Worst time of day: ________

Gastrointestinal
- ❒ Loss of appetite
- ❒ Nausea or vomiting
- ❒ Diarrhea
- ❒ Painful bowel movement
- ❒ Constipation
- ❒ Rectal bleeding
- ❒ Abdominal pain

Hematology
- ❒ Bleeding or bruising
- ❒ Anemia
- ❒ Past transfusion

Genitourinary
- ❒ Frequent urination
- ❒ Painful urination
- ❒ Blood in urine
- ❒ Change if force of urine
- ❒ Incontinence
- ❒ Kidney stones
- ❒ Male-testicle pain
- ❒ Female-irregular menses

Neurological
- ❒ Frequent headaches
- ❒ Lightheaded/dizzy
- ❒ Convulsions
- ❒ Numbness/tingling
- ❒ Tremors
- ❒ Head injury

Musculoskeletal
- ❒ Joint pain
- ❒ Joint stiffness/swelling
- ❒ Weak muscles or joints
- ❒ Muscle pain or cramps
- ❒ Back pain
- ❒ Difficulty in walking

Skin/Breast
- ❒ Cold hands or feet
- ❒ Hives
- ❒ Rash or itching
- ❒ Hair loss
- ❒ Varicose veins
- ❒ Breast pain
- ❒ Breast lump

Psychiatric
- ❒ Memory loss/confusion
- ❒ Nervousness/Anxiety
- ❒ Depression/Mania
- ❒ Addictive behavior

Endocrine
- ❒ Excessive thirst/urination
- ❒ Sugar cravings
- ❒ Hot/cold intolerance
- ❒ Poor sex drive
- ❒ Dry skin

Sleep
- ❒ Problems falling asleep
- ❒ Problems staying asleep
- ❒ Snore
- ❒ Restless legs

Past Surgical History: List year performed next to surgery. Fill in those not listed at the end.

- ❒ Appendix _________
- ❒ Gall bladder ________
- ❒ Tonsils ___________
- ❒ Sinus surgery________
- ❒ Tubes in ears________
- ❒ Hysterectomy_____
  Circle one: Total Partial
- ❒ Tubal Ligation_____
- ❒ Cardiac Bypass_____
- ❒ Catheterization_____
- ❒ Spinal Fusion______
- ❒ Joint Replacement____
  Which joint: ________
- ❒
- ❒
- ❒
- ❒
- ❒
- ❒
- ❒

Family Medical History: To the best of your knowledge, have any blood relatives been diagnosed with the following (Please state the family member(s) in the space provided):

- ❒ Alcoholism ____________________
- ❒ Allergies ____________________
- ❒ Alzeimer's ____________________
- ❒ Anemia ____________________
- ❒ Asthma ____________________
- ❒ Birth Defect ____________________
- ❒ Bleeding Disorder _______________
- ❒ Cancer
  - Member/Type:____________
  - Member/Type:____________
  - Member/Type:____________
- ❒ Depression _______________
- ❒ Diabetes _________________
- ❒ Epilepsy _________________
- ❒ Heart Disease ______________
- ❒ High Blood Pressure __________
- ❒ High Cholesterol ____________
- ❒ Kidney Disease _____________
- ❒ Stroke ___________________
- ❒
- ❒
- ❒

Allergies:

Are you aware of any drug allergies? Yes ____ No ____

Please list the drugs and the reaction you had:

____

____ Environmental allergies?

____

____

Food allergies?

____

____

Social History:

Who lives at home with you?______________________________________

____

Occupation. Please list what you do, approximately how many hours per week and your level of satisfaction:____

____

Has this or any job put you around strong chemicals or smoke? Yes_____ No______

Social History (cont'd):

Tobacco: Yes ___ No ___ How many per day _________ How many years _____
Currently smoking: Yes ___ No ___ If quit, how long ago: _________
Smoke exposure at home: Yes_____ No______

Alcohol: Yes ___ No ___ How many drinks per week _____ How many years _____

Drug use (state which drug and if currently using): ___________________________

Medications: Please attach a separate list if you have one, or if you need extra space.

Name	Dose	How often (if as needed then state average use?)

Supplements: Please be as specific as possible. In addition to listing, please bring all supplements to your appointment.

What is it	Manufacturer	Dosage	How many/day	Why you take it

Stress: Stress and the management of stress if very important to your overall health.

Describe the symptoms that you feel when you are under stress:

____

____

Describe activities or techniques you use to relieve stress:

____
____

Spiritual Life: Having an active spiritual or religious life is an important part of overall health.

Describe your current religious practice (please provide details as to how often and what you do. For example, do you attend church or other ceremony? Any small group study?)

____
____

Previous Complimentary Experiences:

- ❒ Acupuncture
- ❒ Biofeedback
- ❒ Chiropractic
- ❒ Guided Imagery
- ❒ Healing Touch
- ❒ Homeopathy
- ❒ Hypnotherapy
- ❒ Iridology
- ❒ Massage
- ❒ Meditation
- ❒ Naturopathy
- ❒ Reflexology
- ❒ Reiki
- ❒ Psychological Counseling
- ❒ Yoga

Additional Dietary Information: In addition to filling out your two day diet history, please provide honest answers to these questions based on a typical day.

Cups of regular coffee: _____
Cups of decaf coffee: ______
Cups of regular tea: ______
Cups of decaf tea: ______

Regular soda: _____
Diet soda: ______
Crystal Light: ______
Artificial Sweetener packs (Splenda or others): ______

Flavored water or Propel:____
Meals per day: _______
Meals made at home: _____

Pure Health Integrative Medicine

Client Two Day Food Diary

The Center for Integrative Medicine believes very strongly that the food you put in your body plays a large role in your health; both positively and negatively. A food diary is a very valuable resource for determining your current level of nutrition. It will allow us to make recommendations for improvement, as well as consider the possibility of some groups of foods that may be causing symptoms.

Please choose two days to record all of your intake. These days should be considered "normal", don't choose days where your foods are drastically different from usual. Try to record intake for at least one weekday and one weekend day, because food choices can be different. This is preferred but not necessary.

Meal	Day 1	Day 2
Breakfast		
Lunch		
Dinner		
Snacks		
Beverages (soda, coffee, etc.)		