Kristin Markell, MD
Center for Wellbeing
688 Millsap Rd., Suite 100
Fayetteville, AR 72703
Phone: 479-463-3084
Fax: 479-463-3077

Integrative Consultation Form

I look forward to your first visit in our office! Please find a quiet moment to complete this questionnaire to bring to your appointment. I have carefully chosen these questions to address all aspects of your health. Your answers will help me to work with you in a way that best meets your health care needs. Feel free to skip any questions that you do not wish to answer. If there are questions that you prefer not to answer in writing but wish to discuss in-person, we may do so at your appointment.

Today's Date: __________________

First Name ____________________ **Middle Initial** _____ **Last Name** _______________________________

Date of Birth ___/___/___

Phone Number Home (____) ____________ Cell (____) ______________Work (____) ________________

Where can I leave a confidential message? (check one) ___Home ___Work ___Cell

Who referred you to my practice? ____

Birth order (Circle One) Only child, first, middle, or last

Please describe the **major expectations** that you have of your Integrative Consultation:
What are your health goals? What are your health concerns?

____

____

____

____

____

____

What health problems would you like us to address with your consultation? Please rank by priority:

1.____

2.____

3.____

Please list the name of **physicians and complementary medicine providers** who have treated you in the past:

Name	Telephone # (optional)	Profession/Specialty	Dates of treatment From	To

Please list the name of **psychiatrists, psychologists, counselors and psychotherapists** who have treated you in the past:

Name	Telephone # (optional)	Profession/Specialty	Dates of treatment From	To

Please list the name and diagnosis date of any current medical conditions.

___

___

___

Please list the name and diagnosis date of any past or childhood medical conditions.

___

___

___

Please list any diagnostic studies you have had done in the past and the date-
(CT, MRI, ultrasound, colonoscopy, EGD, EKG, Bone density scan, etc.)

___

___

___

What **medications and remedies** are you currently taking? This includes over-the-counter medications, homeopathic and herbal remedies, and nutritional supplements. Use the back of this page if need to add more or bring a list with you to attach.

Name	Dose or quantity per day/ Brand or Manufacturer	When did you start it? Why?

ALLERGIES

Are you allergic to or have you had a “bad reaction” to any medications or other substances? ____YES ____NO

If yes, please specify drug(s), substance(s) and type of reaction: ____

____

Environmental allergies _____YES _____NO. If yes, please describe.

____

____

Food allergies _____YES _____NO. If yes, please describe.

____

Exposure to toxic metals at job or home _____YES _____NO. If yes, please describe.

____

Do you have dental amalgams (silver fillings) or root canals? _____YES _____NO

Please list number of times you have had antibiotics as a Child__________ Teen_________ Adult__________

Please list number of times you have taken oral/IM/IV steroids as a Child_______ Teen_______ Adult_______

Please list any **hospitalizations or surgeries** you have had:

Reason for hospitalization or surgery	**Date**

What **exercise activities** do you do in a typical week?

Activity Type	**Times per week**	**Minutes per time**

Would you like to discuss your exercise regimen? ____YES ____NO

DIET

Do you skip meals? ____

Are you currently on a special diet? Food allergies? Foods you avoid? Vegetarian? Vegan?

____

____

What and how much do you drink on a typical day? (i.e.: water, caffeine drinks, soda, etc.)

____

____

How would you describe your relationship with food? ______________________________________

____

____

What **foods** do you eat on a regular basis?

Breakfast foods	
Lunch foods	
Dinner foods	
Foods you crave (sugar, chocolate, soda, coffee, etc.)	
Foods you dislike	
Snack foods	
Comfort foods	
Food allergies	

How many of your meals (including breakfast and lunch) each week are prepared in a restaurant? ___________

Would you like to discuss your eating habits and diet? ____YES ____NO

Anything about your diet I should know? ____

GUT

How often do you have a bowel movement? ____

Do you have the following? (please circle) small stools, hard stools, diarrhea, loose stools, undigested food in stools, blood in stool, excessive gas, distended belly after eating, foods that make you have an urgent need to have a bowel movement? What foods? ____

Have you had a colonoscopy and/or EGD? ____YES ____NO Date________ Reason____________________

ALCOHOL/BEVERAGE/RECREATIONAL INTAKE

Do you consume any of the following?

	Yes	No	If yes, how much per week	If quit, when
Beer or wine				
Liquor				
Tobacco products/ Vape				
Marijuana, cocaine or other drugs: (please specify)				
Coffee, coke or other drinks with caffeine (please specify)				

Do you feel that you have or had a problem with any of the substances listed above? _____YES _____NO

Have you ever had to cut down on your drinking? _____YES _____NO

Do you get annoyed when someone asks about your drinking? _____YES _____NO

Do you ever feel guilty about your drinking? _____YES _____NO

Do you ever make excuses for drinking or for your behavior while drinking? _____YES _____NO

SMOKING

Do you smoke? _____YES ____NO If yes, how long have you been smoking? _________________________

Have you smoked in the past? _____YES ____NO If yes, how long? _________________________________

Do you have/have you had smoke exposure at home? _____ YES _____ NO

If yes, please explain: ____

____

SLEEP

Overall do you feel that you get enough **sleep**? _____YES _____NO

What time do you go to bed? ________________________________

What time do you wake up? _________________________________

Do you wake up during the middle of the night? _____YES _____NO How often? _____________ About what time? ______________________Are you able to go back to sleep?____________________________________

Do you feel rested upon waking? _____YES _____NO

Do you take anything to help sleep? ____YES ____NO What do you take?______________________________

WOMEN'S HEALTH

Age of first menstrual period__________________ Date of last menstrual period_________________________

Are your periods regular? _____YES or ______NO

First day of most recent menstrual period? __________Usual Flow: _____Heavy _____ Moderate _____Light

Length of bleeding in days_____________________ Number of days between periods? ___________________

Do you have (please circle): Painful Periods, Missed Periods, Spotting Between Periods, Excessive Vaginal Bleeding, Pain with intercourse, bleeding after intercourse, Unusual Discharge/Infection, Recurring Vaginal Infections, Low Libido

If you have gone through menopause, have you had any post-menopausal bleeding? _____YES _____NO

Date of last: PAP/HPV Screen_________________________ Pelvic exam______________________________

Mammogram/Breast Imaging__________________________ Breast exam_____________________________

History of abnormal mammogram? _____YES _____NO Date/Diagnosis_______________________________

History of breast biopsy? _____YES _____NO Date/Diagnosis____

Please list any Family members with Breast Cancer & age at diagnosis? ________________________________

____

Have you ever had an abnormal PAP? _____YES _____NO

If yes, when/treatment____

Number of: Pregnancies _____ Live Births _____ Abortions _____ Miscarriages _____

Have you experienced complications during pregnancy/delivery/or post partum? _____YES _____NO

If yes, please explain. ____

____

____

Contraceptive History

Please circle the method of contraception you are currently using:

Birth Control Pills Type ______________________Diaphragm/Cap __________________________________

IUD Type _______________________________Nexplanon, Depo Provera, Condom and/or Foam, Suppository

Total Years of Use ________________________Date of Last Change _________________________________

Tubal Ligation _____YES _____NO Hysterectomy _____YES _____NO

Partner with Vasectomy _____YES _____NO Other method____________________________________

Problems with current method ____

____

Have you used Contraceptive in the past? _____YES _____NO For how long?________________________

What types? ___________________________________During what years?____________________________

Please list any history of sexually transmitted infections and date of diagnosis? __________________________

____

____

BIRTH HISTORY

Did your mother have a vaginal or cesarean section when you were born? _____Vaginal _____ Cesarean

_____I do not know

Were you born at term? _____YES _____NO _____ I do not know

If No, what gestational age were you born? _____

Were you breastfed? _____Yes _____ No _____ I do not know If Yes, for how long? ____________________

Have you experienced any traumatizing events in your life? ____

____

____

____

What are the greatest sources of **stress** in your life? Describe activities or techniques you use to relieve stress.

____

____

____

What are the greatest sources of **comfort** in your life? What brings you joy in your life?

____

____

____

Who are the people, including members of your family, or animals **who play a very important role in your life?**

Name	Relationship to you	Age	Where do they live?

Who lives with you? ____

____

Are you satisfied with your **personal relationships**? _____YES ____NO Please describe: ________________

If you are a **parent**, do you have any concerns about parenting? _____YES _____NO
If yes, please describe:

Do you consider yourself heterosexual, homosexual, bisexual, transgender, other?

Have you, or a close family member, ever experienced **emotional, physical, mental or sexual abuse or assault**? _____YES _____NO If yes, please explain: ____

Do you use any form of **birth control** or **protection from sexually transmitted infections**? ____YES ____NO
If yes, please describe:

Are you satisfied with your **sexual relationships**? _____YES ____NO
If no, please describe:

Do you belong to an **organized religion or spiritual group**? _____YES _____NO
Please describe your current religious or spiritual practice:

Are you currently a **student**? _____YES _____NO If yes, where? ___________________________________

How many **years of education** have you completed? _____________

Do you have any **difficulties with learning**? _____YES _____NO
If yes, please describe: ____

What is your **job or occupation? _________________________** How many hours a week do you work? _____

Are you satisfied with your **work**? _____YES _____NO

Please describe: ____

____

____

Is there anything about your **work that negatively affects your mental or physical health**?

____

____

____

What is your current **annual household income**? (check one)
_____$20,000 _____$20,000-$40,000 _____$40,000-$60,000 _____$60,000-$80,000 _____$80,000-$100,000
_____$100,000-$200,000 _____>$200,000

Do you have any **concerns** about your current **FINANCIAL** situation? _____YES _____NO
If yes, please describe:

____

____

Do you have any **concerns** about your current **LIVING** situation? _____YES _____NO
If yes, please describe:

____

____

Is there **any other information** about you that you feel is important to tell me?

____

____

____

If you could do one thing in your life, name your **biggest dream, your life's mission**, what would it be?

____

Thank You,
Kristin Markell, MD