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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: _____ **Preferred Pronouns _____**

First Name _____ Middle Initial _____ Last Name _____

Date of Birth ___/___/___ **E-mail Address _____**

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 (Check 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 check): ☐ 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 **sexually active**? ☐ YES ☐ NO With **men, women, or both?** _____

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?

_____

_____

_____

Please attach a **copy of a typical weekday and weekend schedule** for yourself. If you are unsure, track one day during the week and one on the weekend before you come in for your appointment (When you wake up, when you go to bed, typical meals/time, exercise frequency/duration, activities, down time, screen time).

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

_____

_____

_____

_____

Please check the health problems that apply to each family member	**Self**	**Grandparent**	**Father**	**Mother**	**Siblings**	**Child**
Alcoholism						
Allergies/Hay fever						
Anemia						
Arthritis/Rheumatism/Lupus						
Asthma						
Birth Defects						
Bleeding Disorders						
Cancer or Tumor						
Colitis or Crohn's						
Congenital Heart Disease						
Depression/Anxiety						
Diabetes						
Emphysema, COPD						
Epilepsy, Seizures						
Frequent Infections						
Genetic Disease						
Glaucoma, Cataracts, Macular Degeneration						
Gonorrhea/Chlamydia/Herpes/PID						
Gout						
Alzheimer's/Dementia/Parkinson's						
Heart Disease/Heart Attacks						
High Blood Pressure						
HIV, AIDS						
Infertility						
Kidney Disease						

Liver Disease, Hepatitis						
Mental Illness/Suicide (or attempted)						
Migraine Headaches						
Nervous Breakdown						
Obesity						
Osteoporosis						
Peptic Ulcer Disease						
Autoimmune Disease						
Prostate Problems						
Psoriasis, Eczema						
Rheumatic Fever						
Stroke						
Thyroid Disease						
Tuberculosis						
Other:						

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

POINT SCALE:

0 = Never or almost never have the symptom severe

1 = Occasionally have it, effect is not severe

2 = Occasionally have, effect is severe

3 = Frequently have it, effect is not severe

4 = Frequently have it, effect is severe

Digestive Tract

_____ Nausea or vomiting

_____ Diarrhea

_____ Constipation

_____ Bloated feeling

_____ Belching or passing gas

_____ Heartburn

_____ Intestinal/Stomach pain

_____ **Total**

Mouth/Throat

_____ Chronic coughing

_____ Gagging, frequent need to clear throat

_____ Sore throat, hoarseness, loss of voice

_____ Swollen/discolored tongue, gum, lips

_____ Canker sores

_____ **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

_____ Poor memory

_____ Confusion, poor comprehension

_____ Poor concentration

_____ Poor physical coordination

_____ Difficulty in making decisions

_____ Stuttering or stammering

_____ Slurred speech

_____ Learning disabilities

_____ **Total**

Emotions

_____ Mood swings

_____ Anxiety, fear or nervousness

_____ Anger, irritability or aggressiveness

_____ Depression

_____ **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**

Eyes

_____ Watery or itchy eyes

_____ Swollen, reddened or sticky eyelids

_____ Bags or dark circles under eyes

_____ Blurred or tunnel vision (does not include near- or far- sightedness)

_____ **Total**

Head

_____ Headaches

_____ Faintness

_____ Dizziness

_____ Insomnia

_____ **Total**

Joint/Muscles

_____ Pain or aches in joints

_____ Arthritis

_____ Stiffness or limitation of movement

_____ Pain or aches in muscles

_____ Feeling of weakness or tiredness

_____ **Total**

Lungs

_____ Chest congestion

_____ Asthma, bronchitis

_____ Shortness of breath

_____ Difficult breathing

_____ **Total**

Heart

_____ Irregular or skipped heartbeat

_____ Rapid or pounding heartbeat

_____ Chest pain

_____ **Total**

Skin

_____ Acne

_____ Hives, rashes, or dry skin

_____ Hair loss

_____ Flushing or hot flushes

_____ Excessive sweating

_____ **Total**

Other

_____ Frequent illness

_____ Frequent or urgent urination

_____ Genital itch or discharge

_____ **Total**

_____ **GRAND TOTAL**