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HOLISTIC MEDICINE INTAKE QUESTIONNAIRE

Current Date _____/_____/_____

Name _____ **Date of Birth**_____/_____/_____

Welcome to the holistic medicine consult clinic! This questionnaire has been designed so that we can both review your past medical history and other factors in your life that affect your health. The questionnaire makes it possible for us to be more thorough within the constraints of a brief clinic visit. It is long and detailed! Some of this information is already in your medical record, but we are going to ask you to repeat it here to be sure we are getting your complete history. Some questions are very personal - if you do not wish to answer these, please skip over them. You may use an additional sheet of paper if needed. All information collected will be kept strictly confidential. Thank you for your patience.

General Health:.....❒ excellent ❒ good ❒ fair ❒ poor

What is the reason for the visit:_____

Magic Wand: Imagine you had a magic wand and could change three things about yourself and your life. What would they be?

1. _____

2. _____

3. _____

Past Medical Illnesses:

❒ accidents, ❒broken bones, ❒other serious injury
❒ allergies ❒asthma ❒eczema ❒hayfever
❒ anemia (low blood count) ❒ bleeding problems
❒ cancer ❒including skin
❒ lung problems: ❒pneumonia, ❒emphysema, ❒other____
❒ liver ❒kidney problems
❒ heart problems❒high blood pressure ❒other ____
❒ pain: ❒low back pain ❒headaches ❒other
❒ gland problems: ❒ diabetes ❒thyroid trouble
❒ skin disease
❒ gastrointestinal problems: ❒ulcers, ❒diarrhea ❒other____
❒ tuberculosis ❒positive skin test
❒ high cholesterol
❒ sexually transmitted diseases
❒ mental problems: ❒depression ❒anxiety ❒other _____
❒ neurologic ❒seizures ❒MS ❒pinched nerve
OTHER (and dates and details on items checked above): _____
_____
_____

Past Surgery (include approximate date and type of procedure):

Date	Type of procedure

Allergies:

Do you have drug/food allergies/intolerance?....❒ Yes ❒ No (list medication/food and reaction)

Current medications (include prescription drugs, over-the-counter medicines, vitamins, supplements or attach list):

Medication	Dosage	Frequency	Reason

Family History:

Are you adopted?.....❒ yes ❒ no

Please list medical history for:

Relationship	Name(s)	Age	
Mother			❒ Living ❒ Deceased
Father			❒ Living ❒ Deceased
Brother/s			❒ Living ❒ Deceased
Sister/s			❒ Living ❒ Deceased

Has anyone in your family had trouble with the following:
(Include mother(M), father(F), sister(S), brother(B), grandmother (GM), grandfather(GF), aunts(A), uncles(U))

	Yes	No	Unsure	Who
Alcoholism or drug abuse				
Blood clots in legs or chest				
Depression or mental illness				
Diabetes				
Cancer (What organ/s?)				
Heart attack before age 50				
High blood pressure				
High cholesterol				
Stroke				
Tuberculosis				
Osteoporosis				
Mental Retardation				
Liver Disease				
Bleeding Problems				
Congenital Abnormalities				
Other:				

Social History:

Place of Birth: Where were you born? _____ Where did you grow up? _____

What is your current marital status? □ Single □ Married □ Divorced □ Other:_____

If not, have you ever been married or in a committed relationship?.....❒ yes ❒ no

Do you have any children?.....❒ yes ❒ no _____Son(s) _____Daughter(s)

❒ Right handed ❒ Left handed

Education completed:.....❒ grade school ❒ high school ❒ trade school ❒ college ❒ other

Occupation: _____ ❒ employed ❒ unemployed ❒ retired _____

Do you feel stressed at work? ❒ yes ❒ no if yes _____

Exercise: Do you exercise?.....❒No ❒ 1 - 3 times per week? ❒ more than 3 times per week?

What kind of exercise? _____ For how long? _____

Spiritual Life:

Is there a particular spiritual practice or belief system that is meaningful to you?.....❒ yes ❒ no

Name or Description (optional): _____

Daily Nutrition

1. On average, how many times do you eat fast food in a **week**?
   · Never · 1 · 2 · 3 · 4 · 5 · 6+
2. How often do you drink or eat any dairy product in a **week** i.e milk, cheese, yogurt?
   · Never · 1 · 2 · 3 · 4 · 5 · 6+
3. How often do you eat meat in a **week** i.e. beef, pork, chicken, fish ?
   · Never · 1 · 2 · 3 · 4 · 5 · 6+
4. How often do you eat grain in a **week** i.e. bread, rice, pasta, crackers, cereal?
   · Never · 1 · 2 · 3 · 4 · 5 · 6+
5. Do you eat organic ? · Yes or · No
   How many times in a **week**? · 1 · 2 · 3 · 4 · 5 · 6+
6. Do you drink caffeinated beverage? · Yes or · No
   How many cups per **day** of: Coffee _____ Tea _____ Soda _____
7. How many sports drinks, flavored water, juice per **day** ?
   · Never · 1 · 2 · 3 · 4 · 5 · 6+
8. How many servings of fruits and vegetables do you eat in a **day**?
   · Never · 1 · 2 · 3 · 4 · 5 · 6+
9. How many times do you treat yourself in a **week** with candy or sweets?
   · Never · 1 · 2 · 3 · 4 · 5 · 6+

Stress:

Do you feel stress is a problem in your life.....❒ yes ❒ no
Are you currently providing care for a disabled or elderly family member? .....❒ yes ❒ no
Do you have concerns about your children or your relationship with them?.....❒ yes ❒ no
Are you afraid of your own temper or that of anyone else in your family?.....❒ yes ❒ no
Do you have problems with getting angry frequently or at little things? .....❒ yes ❒ no
Do you sometimes feel out of control?.....❒ yes ❒ no
Do you sometimes feel you are no good or you can't do anything right?.....❒ yes ❒ no
Have you ever thought about or tried to commit suicide .....❒ yes ❒ no
Does someone you live with have serious health or emotional problems? .....❒ yes ❒ no
Have you or anyone on your block been shot or mugged in the last year? .....❒ yes ❒ no
Is there any history of violence in your family?.....❒ yes ❒ no
Has anyone close to you ever physically hit you or hurt you? .....❒ yes ❒ no
Do you feel unsafe in your current relationship?. .....❒ yes ❒ no
Is there a partner from a previous relationship who is making you feel unsafe now? .....❒ yes ❒ no

Social Support:

How do you deal with conflict in your family?_____

_____

Who provides you with emotional support(family, close friend, religious advisor, other)?

_____

Other providers involved in your care: Do you see other health care providers other than your primary doctor *(such as a therapist, other physicians chiropractors, accupuncturists, naturopaths, herbalists, etc.)* on a regular basis?.....❒ yes ❒ no

Who do you see?

Name	Profession	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Would you like your integrative provider here to consult with/coordinate your care with your other provider(s)?.❒ yes ❒ no

Are there other issues that you would like to discuss with your provider? Please describe: _____

_____

_____

_____

PROCEDURES	**DATE**
Last Physical Exam	
Lab Results/Blood Work	
Urine Test	
MRI	
CT Scan	
EKG	
EEG	
X-ray	
Ultrasound	
Colonoscopy	

Review of Symptoms (check off symptoms within the last 3 months)

GENERAL	YES	NO	NOSE	YES	NO
Difficulty falling asleep			Runny nose		
Difficulty staying asleep			Bleeding		
Number of hours of sleep per night			Polyps		
Are you a nervous person ?			Sneezing		
Are you frequently ill?			**MOUTH**		
NEUROLOGICAL			Sore		
Frequent or severe headaches			When were your teeth last checked?		
Fainting, unconsciousness			When were your teeth last cleaned?		
Problems with coordination			**EARS**		
Seizures			Hard of hearing		
Dizziness			Ringing in ears		
Weakness			Ear infection or discharge		
Numbness					
Depression			**GASTROINTESTINAL**		
Paralysis			What is the most you ever weighed?		
SKIN			What was your weight last year?		
Unusual pigmentation			What is your weight now?		
Itching			Have you lost weight recently?		
Bleeding			Loss of appetite?		
Loss of hair			Difficulty Swallowing		
Lumps or changing moles			Stomach Pain		
EYES			Heartburn		
Color blindness			Ulcers		
Double vision			Vomiting		
Pain in eyes			Vomiting up blood		
Blurred vision			Gallbladder disease		
Do you wear glasses or contacts?			Hepatitis		
Do you have glaucoma?			Jaundice		
When were your eyes last checked?			Constipation		
Macular Degeneration			Diarrhea		

GASTROINTESTINAL	YES	NO	GENITOURINARY	YES	NO
Do you take an Iron supplement			How many times do you urinate in the daytime?		
Blood in bowel movement			How many times do you urinate in the nighttime?		
Hemorrhoids			Pain when urinating		
Rectal problem			Passed blood in urine		
Hernias			Change in urine color		
			Urine or bladder infection		
LUNGS			Kidney stones… Year:_____		
Asthma/wheeze			Trouble starting urine		
Bronchitis			Do you lose control of bladder		
Chronic Obstructive Pulmonary disease			Prostate trouble. Last time check:_____		
Emphysema			**GYNECOLOGICAL**		
Hoarse voice			Pain or lumps in breasts		
Cough			Discharge from breasts		
Ever coughed up blood			Do you examine yourself regularly?		
Shortness of breath?			**MENSTRUAL HISTORY**		
Lying down			Age at onset: _____		
Sitting			Age of menopause_____		
Standing			Regular or Irregular Cycle_____days		
Walking			Duration of flow:_____days		
HEART			Flow: ❒heavy, ❒ medium or ❒light		
Chest pain: Rest/exertion			Last Period: _____		
Palpitations (pounding of chest)			Recent spotting ?		
Irregular heart beat			Hot flashes?		
Ankles swollen			Vaginal dryness		
Heart problem or heart attack			Vaginal discharge/color?		
Heart murmur			Last pap smear:_____		
			Number of pregnancies:_____		
BONES AND JOINTS					
Are joints painful or swollen					
Muscle cramps					
Arthritis					
Gout					

PROBLEM LIST

Please rate how you have been feeling during the past week including today.

KEY: 0 - NONE 1 - MILD 2 - MODERATE 3 - MARKED 4 - SEVERE

1. Depressed sad	0	1	2	3	4	26. I move slower sit in one place for long periods	0	1	2	3	4
2. I am so depressed that not even good new would cheer me up	0	1	2	3	4	27. I'm so restless I can't sit still or relax	0	1	2	3	4
3. Angry, Irritable, hostile	0	1	2	3	4	28. Thoughts slowed down	0	1	2	3	4
4. Decreased self esteem or self confidence low thoughts about my self	0	1	2	3	4	29. Racing Thoughts	0	1	2	3	4
5. Guilt Feelings, feeling like a burden family or society	0	1	2	3	4	30. Mood worse in morning	0	1	2	3	4
6. Hopelessness, things will not get better	0	1	2	3	4	31. Mood worse in evening	0	1	2	3	4
7. Helplessness I can change things	0	1	2	3	4	32. My mood change very rapidly	0	1	2	3	4
8. Trouble falling asleep	0	1	2	3	4	33. Thoughts of suicide wishing I were dead or not caring if I live	0	1	2	3	4
9. Waking up in the middle of the night	0	1	2	3	4	34. Intent to kill myself	0	1	2	3	4
10. Waking in the morning 1 - 2 hours before I need to	0	1	2	3	4	35. Wanting to hurt or punish myself (not suicide)	0	1	2	3	4
11. Sleeping more than usual	0	1	2	3	4	36. Anxious, nervous, worried	0	1	2	3	4
12. Drowsy during the day	0	1	2	3	4	37. Psychical anxiety symptoms like my heart beating oddly being short of breath tremor, butterflies in my stomach frequent urination sweating, muscle tension, numbness in my hands or feet	0	1	2	3	4
13. Fatigue low energy hard to get going	0	1	2	3	4	38. So afraid of certain things or situations that I avoid them	0	1	2	3	4
14. Decreased appetite	0	1	2	3	4	39. Sudden severe feelings that something terrible is going to happen like I will die, go crazy or pass out	0	1	2	3	4
15. Increased appetite	0	1	2	3	4	40. Hearing voices or seeing things that are not there	0	1	2	3	4
16. Decreased weight	0	1	2	3	4	41. Believing things that others do not believe	0	1	2	3	4
17. Increased weight	0	1	2	3	4	42. Feeling suspicious of others that others want to hurt me or are against me	0	1	2	3	4
18. Decreased sexual interest	0	1	2	3	4	43. Unpleasant unrealistic thoughts go over and over my mind an I cant's stop them	0	1	2	3	4
19. Increased Sexual interest	0	1	2	3	4	44. Feeling compelled to do senseless things over and over	0	1	2	3	4
20. Decreased interest in usual actives	0	1	2	3	4	45. Feeling I am some other person or am outside my body	0	1	2	3	4
21. Decreased involvement in usual activities withdrawn	0	1	2	3	4	46. Feeling things are not real like in a fog or dream world	0	1	2	3	4
22. Decreased pleasure or less enjoyment of usual activities	0	1	2	3	4	47. Worried about my physical health	0	1	2	3	4
23. Decreased memory	0	1	2	3	4	48. Feeling rejected by other	0	1	2	3	4
24. Decreased concentration	0	1	2	3	4	49. Unable to control my impulses	0	1	2	3	4
25. Indecisiveness unable to make decisions	0	1	2	3	4	50. Drinking alcohol or using recreational drugs	0	1	2	3	4

NAME: _____ DATE: _____

Epworth Sleepiness Scale

Name:_____ Today's date: _____

Your age (Yrs):_____ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	___
Watching TV	___
Sitting, inactive in a public place (e.g. a theatre or a meeting)	___
As a passenger in a car for an hour without a break	___
Lying down to rest in the afternoon when circumstances permit	___
Sitting and talking to someone	___
Sitting quietly after a lunch without alcohol	___
In a car, while stopped for a few minutes in the traffic	

THANK YOU FOR YOUR COOPERATION